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ABSTRACT

This booklet examines the first 2 1/2 years of The Special Supplemental Food Program for Women, Infants, and Children (WIC), designed by Congress to provide food and nutrition information for low-income pregnant women, nursing mothers, and children up to age 4. Problems with the implementation and functioning of the nutrition program are discussed. Specific criticisms are made about the program administration by the Department of Agriculture and the States. Descriptions of some State WIC programs and recommendations for future WIC program operation are provided. Appendices include a bibliography of medical research on malnutrition, a list of government reports on WIC, WIC caseloads and budgets, a list of local WIC sponsors, and legislation authorizing WIC. (BRT)

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WOMEN AND CHILDREN FIRST . . . OR LAST?

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A Report on the Special Supplemental Food Program for Women, Infants and Children

by **Virginia Fleming**

PS 008140

THE CHILDREN'S FOUNDATION
WASHINGTON, D. C.

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The WIC Advocacy Project of The Children's Foundation has for nearly three years monitored this federal child nutrition program. We publish monthly bulletins for local sponsors and community committees. We relay information to Congress and the national administration of WIC, and in turn keep a flow of analyses and information going out to local groups by means of fact sheets, telephone communications and technical assistance. This project is supported primarily by a grant from the Herman Goldman Foundation, to which we owe special thanks for the funds to publish this report.

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. . . . . OR LAST?

A Report on the Special Supplemental Food Program for Women, Infants, and Children

by Virginia Fleming

The Children's Foundation
Washington, D.C.

April, 1975

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Introduction

The Children's Foundation is a non-profit organization that monitors and advocates improvements in public policy affecting the nutrition of America's children—particularly poor children and their families. Since 1969 we have worked with government agencies and community groups on a number of food programs. We welcomed in 1972 the passage of legislation establishing a new pilot nutrition program: The Special Supplemental Food Program for Women, Infants and Children (WIC).

In the two and one-half years of the operation of WIC we have been a supporter of its potential usefulness, a frequent critic of its administration, an advisor to local groups who need and want to participate in it, a consultant to Congressional committees seeking information about its operation, and a publicist for the whole story.

WIC was initially designed as a two-year pilot program, through June, 1974, to distribute free nutritional supplements to low-income pregnant women, nursing mothers and children up to age four. It was later extended by Congress through another fiscal year, until June, 1975, and its authorization increased from $20 million a year to $100 million for the third year. Now, in the spring of 1975, Congress must decide whether to make it a permanent program, refine it for further study, fold it into a related program, or abandon it altogether.

Some preliminary official reports and evaluations of WIC have already been released, and there will be more. This is an unofficial report, by a private organization which has several staff members engaged full time on working with this program in the public interest. It is a summary of what we have learned about the need for WIC, the issues related to its implementation, and the merits and problems of its many grantee agencies. It is also a presentation of our hopes and recommendations for its future.

Like most of those who work with federal food assistance programs, we recognize daily that making such programs more effective is not the only, nor even the best way to combat hunger and malnutrition in America. Were the benefits of our economy more equitably distributed, were more fundamental tax and economic reforms accomplished, the need for welfare and food assistance would diminish. We can never lose sight of the real goal, even as we work to make food and nutrition programs more accessible and more responsive to the immediate need.

Barbara Bode
President

Raymond Wheeler
Chairperson

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To admit the existence of hunger in America is to confess that we have failed in meeting the most sensitive and painful of human needs. To admit the existence of widespread hunger is to cast doubt on the efficacy of our whole system. If we cannot solve the problem of hunger in our society, one wonders if we can resolve any of the great social issues before the nation.

Senator George McGovern
1971

I. The Consequences of Malnutrition

Americans have become increasingly aware in recent years of the extent of hunger and malnutrition among many of our people. The documentation mounts relentlessly.

Of those who suffer from malnutrition, infants and young children represent a specially vulnerable group. The early formation of their bones, their nervous systems, and their brain cells will influence their lifelong capacity for health and productivity. When mothers are undernourished during pregnancy, and when children are undernourished during the critical first months and years of their lives, damage is done which can never be corrected.

Over the last decade medical science has demonstrated beyond doubt the devastating effects of malnutrition:[1]

- The single most important factor in a baby's birthweight is the nutrition and weight gain of the mother. The more the mother gains, the larger the child will be at birth.
- Infant mortality increases as birth weight decreases. Mortality rates rise sharply when the birth rate drops below 5 1/2 pounds.
- Children who survive malnutrition can still be handicapped for life.
- Birth defects are three times as common among low weight babies.
- There is a striking correlation between children's weight at birth and their later intelligence. Brain cells divide most

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rapidly before birth, and have finished dividing by 18 months; they will later grow and develop, but the number of cells is determined very early. Babies who are undernourished just before and after birth have significantly fewer brain cells. Thus, while mental retardation is not curable, much of it can be prevented by proper nutrition.

If pregnant women must eat nutritious food, especially protein, and gain adequate weight to produce babies of normal weight and development, then the odds against poor women and their children are inevitably greater. And indeed, the statistics bear out that fact:

- Two-thirds of all households with annual incomes less than $3,000 eat less than the Department of Agriculture's basic dietary standard.[3]
- Among the poorest families 30.7 percent of the babies are born below normal birth weight; among the richest families only 21 percent of the babies are less than normal weight.[3]
- The incidence of low birth weight among nonwhite infants rose from 10.4 percent in 1950 to 13.8 percent in 1964.[4]

Poverty is closely linked to low birth weights; low birth weights are closely linked to infant mortality. A similar pattern has been established between poverty and mental and physical handicaps: an American Medical Association seminar reported in 1973 that three-fourths of all retarded children come from poor families.

Thus, while all members of low-income families are considered "at nutritional risk", pregnant women and young children are a special and critical group.

> Adequate diet is more important than compulsory education. For if the brain cells don't develop in the first six months of life, they never will. And without enough brain cells you can't learn. If you're anemic, as almost all malnourished children are, you don't even have the energy to try. Some folks opposed free schools a hundred and fifty years ago. Today some folks oppose free food for children. Yet an infant's diet determines his life. Poor diet makes for poor people.
>
> *Dr. Donald Pinkel*
> *Medical Director, St. Jude's Hospital*
> *Memphis, Tennessee 1973*

Nor is the problem just a small and specialized one. Infant mortality rates are lower in fourteen other countries than in the United States, which loses 19 babies in every thousand; over one million children under four years old in America are mentally retarded or physically impaired; 4.6 million pregnant women and young children in America are at nutritional risk.

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INFANT MORTALITY RATES FOR SELECTED STATES HAVING HIGH PER CAPITA INCOMES

(Per thousand live births)

	Mortality Rate[1]		Per Capita
	White	Nonwhite	Income[2]
California	16.2	23.9	$10,642
Massachusetts	17.5	15.5	10,835
New York	17.1	29.7	11,201
New Jersey	17.5	30.2	11,407
Hawaii	18.0	18.9	11,554
Connecticut	15.6	30.2	11,811

INFANT MORTALITY RATES FOR SELECTED STATES HAVING LOW PER CAPITA INCOMES

(Per thousand live births)

	Mortality Rate[1]		Per Capita
	White	Nonwhite	Income[2]
Mississippi	19.3	39.7	$6,607
Arkansas	18.2	32.1	6,273
Alabama	18.4	35.8	7,266
West Virginia	23.2	27.5	7,415
Kentucky	18.8	28.0	7,441
Tennessee	19.5	32.1	7,447
Louisiana	19.5	32.3	7,530
South Carolina	18.6	30.2	7,621
New Mexico	19.7	28.9	7,849
North Carolina	19.2	35.8	7,967
Georgia	17.2	33.8	8,167
Florida	17.5	34.4	8,267

1. "Statistical Survey: Infant Birth and Death Data." Table 1, "Infant Deaths and Infant Mortality Rates per 1,000 Live Births by State and Color, 1970 Provisional Data." National Center for Health Statistics.
2. Taken from 1970 census — General social and economic characteristics, table 47.

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The human sorrow—the loss and pain to families whose children are dying or deformed—is matched by the social waste of resources. National programs directed to improving nutrition are both less expensive and more humane than the ultimate cost of keeping premature babies alive, of keeping severely handicapped children in public institutions, of spending welfare and education dollars on children whose anemia, retardation or lack of physical energy makes them unproductive in return.

Malnutrition in America has sorrowful and expensive consequences.

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CONSIDER THE CASE OF LUCY, AN INFANT.

She was born at John Gaston Hospital and was discharged with her mother after three days. Her weight was 6 pounds 4 ounces at birth.

For all purposes, she was a healthy, normal baby.

But five weeks later, Lucy's 19-year-old mother brought her to a Memphis and Shelby County Health Department neighborhood clinic. The child had gained less than a pound since birth.

A nurse at the clinic told Lucy's mother that the baby was ill and must see a physician.

But Lucy's mother was poor. A waitress, she worked 40 hours a week for $20 plus tips.

Doctors are a luxury when you're that poor. And a trip to City of Memphis Hospital for free treatment when you have no transportation is a stream of buses, transfer tickets, corridors, waits and referrals to other offices.

Lucy got sicker.

Three weeks later, a neighborhood aide for Memphis Area Project-South heard about the child, and a nurse was called from St. Jude Children's Research Hospital. On Lucy's record at St. Jude is the nurse's first impression:

"Marasmic appearing child. Thin, scrawny, with protuberant abdomen, loose skin. Is highly irritable."

Lucy was taken to St. Jude, where a pediatrician examined her. His diagnosis was that Lucy was a victim of malnutrition and on the verge of starvation.

"When someone has a disease, you give them medicine or a vaccination for it," says Dr. Donald Pinkel, medical director at St. Jude. "Malnutrition is a disease. And food is the vaccine."

So the pediatrician prescribed food for Lucy. No exotic medicines or vaccines. Just food.

He instructed the mother to feed Lucy a prepared infant formula, such as Similac or Infamil, instead of an evaporated milk formula the mother had been using. The prepared formula was provided free by St. Jude.

In the beginning, Lucy's growth slowly increased. Then, she gained suddenly. She sprouted. Five pounds were gained in a few weeks. More than six inches in length in less than a month.

After six months, she was above the 50th percentile for both height and weight. She was healthy, robust and pleasant. Lucy appeared to be a bouncing, normal baby.

But she wasn't.

The story does not have a happy ending.

Despite her rapid growth and new strength, Lucy's head circumference remained small. To doctors, this means her brain had failed to fully develop.

According to startling new research into the nutrition of children at St. Jude, doctors have discovered that Lucy's brain will never fully develop.

She will be mentally retarded, or at least, a slow learner, the rest of her life. Nothing can be done to help her.

"It has been shown that by the end of the first six months of life, a child normally develops all of its brain cells," says Dr. Pinkel. "This is a critical period of growth for the brain and nervous system. If this growth is in some way impaired, it results in irreparable stunting for the rest of that child's life."

Lucy is a victim of poverty. There are thousands like her in Memphis. There are millions like her in the United States.

Memphis Commercial Appeal
December 27, 1970

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The campaign to abolish hunger in America is now almost six years old... We have acted to improve the nutritional welfare of every group with the voice and ability to speak for its interests, and we have continued to ignore the one group which cannot speak — and which is the most vulnerable to malnutrition.... infants from six months prior to birth and to six months after birth...

Senator Hubert H. Humphrey
Congressional Record
August 16, 1972

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II. The National Response: Food Programs for Mothers and Children

In 1946, Congress took the first significant step toward responding to the nutritional needs of children. The **National School Lunch Act,** since revised and expanded many times, subsidizes school lunches, which are meant to provide one-third of a child's daily nutritional needs. Some are available at a reduced price, and for the poorest children the meals are free. In 1968, legislation added a school breakfast program.

Battles over the growth and implementation of these two programs continue, but the principle is firmly established. There are still 18,000 schools which refuse to offer these lunches, and another 800,000 schools which do not offer breakfasts, but the national mechanism and funding are in place.

> Hunger is still a serious problem in many urban and rural parts of the United States. There are still millions of people without a proper diet and without access to Federal, State, or local food assistance. In my own State of New Jersey which has a good record in providing food assistance to the needy, there are still 210,000 poor people who get no food assistance whatsoever. And, in our largest city, Newark, and its surrounding county, over 48,000 poor people get no food assistance.
>
> *Senator Clifford Case*
> *Congressional Record*
> *May 30, 1973*

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In 1964, Congress initiated the **Food Stamp Program** to enable poor families to buy food at reduced prices. Its outreach is far from complete; today 18 million people participate out of a possible 40 million. But it is an important emergency measure.

> We have shown beyond doubt in South Carolina that it is better to feed the child than jail the man. Money spent to give a poor child a nourishing breakfast and a good school lunch are worth literally millions of dollars in savings to the American taxpayer. A child who can be launched into life with a healthy body and healthy mind can be a life-long contributing member to society. A child whose body and brain have been stunted by malnutrition will be a constant reminder to society of its unfulfilled obligations.
>
> *Senator Ernest F. Hollings*
> *Congressional Record*
> *August 16, 1972*

Then in 1968 Congress expanded the School Lunch and Child Nutrition Act legislation in two directions: a program to feed children of school age during the summer, and a year-round program to feed low-income children and the children of working mothers in day care centers and Head Start programs. These **Special Food Service Programs** are limited in funds and hampered by restrictive administration. They nevertheless demonstrate an understanding that pre-school children need food as much or more than school children, and that nutritional needs do not take a summer vacation.

In response to the political pressure generated by the Poor Peoples Campaign in 1968, the Department of Agriculture began the **Commodity Supplemental Food Program.** This provides free government purchased commodities to low-income, nutritionally at risk pregnant women, new mothers, and children under age six. USDA supplies only the food; all other costs are the responsibility of participating states and local sponsors.

USDA has never promoted this special commodity distribution. On the contrary, they have done everything in their power to contain its growth. They announced restrictive policies throughout 1970 and 1971, and in 1973 subtly conveyed their intention to discontinue the program at the end of fiscal year 1974. Public support rallied in the spring of 1974, however, and in June Congress passed the legislation needed to carry it on.

USDA's actions have successfully limited this program; today there are only 130,000 participants.

It became apparent, however, that this growing pattern of food assistance was still not solving the problem of infant mortality and morbidity, because it was not focussed on the most critical stage of human development—just before and after birth.

Testimony from research programs at hospitals in Memphis, Baltimore, Detroit and St. Louis gave Congress some concrete evidence that a clinic-based food distribution program could increase the size and health of low-

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> Anemia could be virtually eradicated in Memphis. It's ironic to be spending sometimes up to a hundred and fifty dollars a day on hospital care for a baby that has been damaged by a disease that can be prevented for a dollar fifty a week.
>
> *Dr. Paulus Zee*
> *Nutrition Director, St. Jude's Hospital*
> *Memphis, Tennessee 1973*

income infants. Better early nutrition could prevent—at much lower cost—some of the problems that children's hospitals spend countless dollars trying to cure.[5]

Congress thus decided to experiment with an additional way to reach this highly vulnerable group: poor mothers and children.

The commodity-based program was valuable, but a number of groups (including the Urban Affairs Council at the White House, which included the Secretaries of Agriculture, Commerce, and Health Education and Welfare) had for several years been recommending an alternative program providing food to the same group through a cash voucher system.

The new program would be different, and geared to its specific goals, in these ways:

- The food would be entirely free, rather than requiring a portion of family income as do Food Stamps.
- The food would be specifically chosen to provide correct nutritional supplements for pregnancy and infancy.
- The program would be administered through health clinics, so that women would be encouraged to take advantage of health care and nutrition education at the same time.
- It would not be tied to the cumbersome logistical apparatus of the commodities program.
- It would include grants for administrative costs so that local sponsors could afford to undertake its operation.

Thus, in 1972, Congress amended the Child Nutrition Act to create a Special Supplemental Food Program for Women, Infants and Children.

> The irreversible effect of malnutrition during infancy will eventually cost taxpayers much more in remedial education, medical, and public assistance expenditures than the modest cost of the food packs offered by the WIC program.
>
> *Congressman Edward Koch*
> *Congressional Record*
> *March 5, 1975*

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"When we speak of fetal and early infant malnutrition we are speaking of nothing less than wasted lives and lost potential, of stunted minds and stunted bodies. It is simply that the damage—when it is serious, prolonged, and when it occurs in critical stages of development—can never be made up. Were we to begin all over, we should begin with a vigorous, comprehensive Federal effort in this area above all others."

National Nutrition Policy Study
Report to Senate Select Committee
on Nutrition and Human Needs
June, 1974

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III. The WIC Program: Legislative Intent

The Special Supplemental Food Program for Women, Infants and Children—usually called "WIC"—is designed to meet the nutritional needs of young children from low-income families at their most critical stage of development, and to provide extra protein-rich food to their high risk mothers during pregnancy and while they are nursing.

Its authorization is Section 17 of Public Law 92-433 [86 Stat. 724], approved on September 26, 1972. (See Appendix F.)

WHAT THE LAW REQUIRES

Section 17 [a] defines the population eligible to receive benefits: **"pregnant or lactating women and . . . infants determined by competent professionals to be nutritional risks because of inadequate nutrition and inadequate income."** Participants must live in areas which have significant numbers of such women and children. Children may participate up to age four.

The legislative definition "at nutritional risk" specifies people from low-income populations characterized by inadequate nutritional patterns, as

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well as low-income mothers who have a history of high-risk pregnancy. (Section 17[f] [1].)

Unlike the Food Stamp program, WIC's focus is on food value as well as food purchasing power. The program is to provide food supplements "containing nutrients known to be lacking in the diets of populations at nutritional risk and, in particular, those foods and food products containing high-quality protein, iron, calcium, vitamin A, and vitamin C". (Section 17[f] [3].)

The legislation guarantees a close association of WIC supplemental food distribution with health care services. The program is administered by the Department of Agriculture, which makes cash grants to the health departments of each state, which in turn provide operating funds to "local health or welfare agencies or private non-profit agencies . . . serving local health or welfare needs". (Section 17[a].) **Not only is the food beneficial in itself, but the distribution process also encourages mothers and children to make use of the health facilities available to them.**

Section 17[c] of the law sets a limit of 10 percent of the total federal funds on administrative costs for running the program.

The legislation calls for two kinds of evaluation of this pilot program. From medical records to be kept by state or local agencies the Secretary of Agriculture is to determine the medical benefits achieved by WIC in overcoming malnutrition and its resulting disabilities, and from the administrative experience the Secretary and the Comptroller General of the United States are to submit a general evaluation.

After two trial years, fiscal 1973 and 1974, at a funding of $20 million each year, the Congress is to decide whether WIC should be made a permanent program with a nation-wide scope.

HOW THE PROGRAM WORKS

When the Department of Agriculture eventually implemented WIC—slowly and reluctantly, as the next chapter makes clear—the program developed this pattern:

USDA decides which applicants will get grants to run programs, based on a state's submission of approved applications. USDA also determines the monthly food package: for infants up to twelve months old there is iron-fortified formula, iron-fortified infant cereal, and canned fruit juice. Nursing mothers and children from one to four years received a daily quart of milk plus eggs, cereal and juice.

State health departments must approve and monitor local sponsors and their operations, and forward records and evaluations to regional FNS offices. State agencies must also decide how to divide the administrative money (ten percent of incurred food costs) between its own administrative needs and those of local sponsors. The way in which the food is distributed is approved or designed by the state. Methods of food delivery include vouchers or food checks which are redeemed at local grocery stores, or direct distribution of purchased foods from warehouses or delivery trucks.

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A local WIC sponsor is responsible for publicizing the program, certifying the eligibility of participants, providing the food or the vouchers, conducting medical tests, keeping records, and reporting to USDA through state agencies. It must also see that local grocers give the correct foods in return for vouchers, and turn in their vouchers promptly for redemption.

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"As always, we must take the USDA by the hand and show it what compassion for people is all about."

Senator Hubert H. Humphrey
Testimony before Senate Agricultural
Research and General Legislation Subcommittee
July 28, 1972

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IV. The WIC Program: Administrative Reality

THE DEPARTMENT OF AGRICULTURE: AN UNWILLING ADMINISTRATOR

The Department of Agriculture's negative attitude toward food programs for low-income people was well known long before 1972; a battle between Congressional intent and administrative redefinition has been going on for some years. But the story of WIC represents an extreme case of delay, neglect and frustration.

Getting USDA Started

The Department's first reaction to the creation of WIC was to try to get rid of it altogether. Letters and negotiations proceeded with the Department of Health, Education and Welfare, on the grounds that WIC included a medical evaluation component that USDA was "not organized" to undertake. Five months of potential operation thus evaporated before HEW's definitive refusal to take over.

Having failed in that diversion, USDA tried another. In February and March officials testified that none, or very little, of the funds could be spent in the first year of operation. Their clear intent at this point was to design a "small, statistically valid medical evaluation of a program of food intervention",* spending as little of the appropriation as possible, and ignoring the chief intent of the legislation, which was to get nutritious foods to women and children in need of them.

In March, 1973, responding to Congressional and community pressure, USDA finally organized a Task Force to work out its implementation of WIC.

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By June, with the 1973 fiscal year running out and no program in sight, the Senate Select Committee on Nutrition and Human Needs reconvened and called USDA officials to account for their failure. Two weeks later a group of individuals potentially eligible for the program and organizations eager to apply for grants filed suit against the Secretary of Agriculture. Under pressure from the Court, USDA signed an immediate consent order which assured that the first year's funds of $20 million would be carried over into the second, making a total of $40 million available in fiscal year 1974. The judge also ordered that program regulations be issued by July 6, 1973.

Early in August, the Court found in favor of the plaintiffs and ordered USDA to process and grant applications so that the entire $40 million would be spent in fiscal 1974.

Although a few grants were made in the fall of 1973, the slow pace called for an additional prod. More than 300 clinics had applied for grants, and were waiting for a chance to begin work. The plaintiffs therefore returned to court in November to seek a contempt citation against Secretary Butz. Although this was denied, the judge ordered USDA to announce all the year's grants by December.

A sufficient number of grantees was announced by the end of 1973 to account for available funds, but during the following winter it became clear that not all of them could gear up fast enough to use the money which had been allocated. Only 110 of 255 sites were actually in business by March. Thus the Department made some additional short term grants for the remaining months of fiscal 1974, in order to commit all the funds.

In the meantime, Congress had recognized that the program must be extended into a third year to compensate for its delayed implementation and to allow for the completion of the research project; authorizing legislation had been passed for an extension at the original $20 million level.[7] But because so many short term grants had eventually been made, the annualized funding level in fact far exceeded even the $40 million USDA was required to spend during the second year. Congress thus again revised its mandate, and passed another bill in June raising the authorization to $100 million and again requiring any unspent funds to be carried over into the new fiscal year.[8]

The Medical Research Maneuver

In the beginning, USDA used the medical evaluation of WIC as a diversion. There was no program, only intense concern to evaluate it. But after months of official consultation, the unveiling of USDA's request for research proposals in August, 1973, was less than a success.

Doctors who read it warned community groups that the large blood samples required for infant participants could only be taken from the jugular vein of a baby, a process which multiplies the possibility of infection, anemia or trauma in the infant. The tests would be an affront to dignity, a trade-off of blood for food. They would also be medically dangerous; USDA could not guarantee that well-trained technicians would do the testing. Community pressure soon mobilized to force the Department to abandon this requirement. Community groups demanded that USDA adopt existing

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HEW Guidelines on the Protection of Human Subjects. The jugular blood test requirement was dropped in late September; some months later the HEW Guidelines were incorporated into WIC regulations.

> The blood tests were dangerous . . . They smacked of experimentation on the poor as in the Tuskegee experiment. Didn't anyone realize that such tests are not only dangerous for small infants, but that such requirements would discourage hungry persons from participating in the programs? Or did some see this as a means of saving money by restricting participation . . .? Was it a means of proving eventually that such food programs are not needed, and providing a good excuse for . . . getting USDA out of food programs for the poor?
>
> *Dr. Maryann Mahaffey*
> *Wayne State University*
> *Councilwoman-elect, Detroit*
> *Testimony to Senate Select Committee*
> *on Nutrition and Human Needs*
> *December 6, 1973*

Reaction among medical researchers to the scientific aspects of the jrequest for Proposal was less dramatic but equally negative. Only one university applied. USDA's own consultants advised that they could not recommend a contractor until revisions in the outline were made.

USDA selected the one potential contractor, the University of North Carolina School of Public Health, and renegotiated a study design and data collection plan. There were now less than twelve months left of WIC's authorization, so the contractor declined to begin. Not until November, 1973, when new legislation guaranteed funding through the entire research period, was the contract signed.

A variety of problems led many observers to the conclusion that it would not in any case be a useful evaluation. A report of the General Accounting Office of the United States, which is required by law to evaluate the WIC program, summarized the major criticisms in its 1974 report:

- any attempt to determine the medical benefits of this nutritional assistance program is necessarily limited by the absence of commonly accepted definitions and guidelines, lack of control groups, and the inability to isolate single factors for study;
- in spite of these limitations some useful information could be gathered, if the data were reliable. But "because of weaknesses in training, pretest procedures, and procedures for controlling data quality . . . the Service and the university cannot insure that standardized procedures are being used . . . nor can they document the degree of data reliability."[9]

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Thus questioning the credibility and usefulness of the major evaluation contract, and mindful of the savings which terminating the contract could still make possible, GAO wondered if "Congress may wish to advise the Secretary whether it wants the evaluation to be continued".

No action was taken, however. Research continues, and the final report from the university is due in October, 1975.

Though we felt that the food would be beneficial to the eligible population, we regretfully had to resign ourselves to a non-participatory role for the following reasons:

1. Time period too short to submit proposal.
2. Risks to the patients would outweigh the benefits, especially to infants and children (50cc or 5 tubes too much blood to be drawn!). Could cause anxiety among children and pregnant women and preclude their keeping regular medical examination.
3. Medical data sought in relation to food consumed would be difficult to monitor.
4. Food only available for short period of time (October 1973 to June 1974).
5. Choice of food provided was poor.

. . . we are very concerned that we were not able to take advantage of this program. In the future should less trauma be required of the patient we would be interested in this program for our community.

A letter from the Mott Children's Health Center representing eight Michigan health services. August, 1973

Regulations

The usual function of federal regulations is to define technical aspects of a program so that potential grant applicants will know whether they qualify, and what is expected of them. The delay, uncertainty and restrictiveness in the USDA regulations have instead hampered WIC's effectiveness.

Under court order the first set of regulations were finally published in July, 1973, ten months after the law passed and after the first fiscal year of the program was over. An agreement reached in court stipulated that the normal 30 day comment period would be waived; the regulations became effective upon release.

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The only problem was that someone in Washington forgot to send guidelines on the new program to the states. The first I heard about the project was from someone in Newark who was already applying for funds. That was last summer.

Mrs. Margaret Zealand
Nutrition Consultant, New Jersey
State Department of Health
May, 1974

Running the program will be a snap compared with the trouble we had for eight months just getting our money out of the pockets of the Agriculture Department.

Mrs. Judy Wilson
Director, WIC Project
Newark, New Jersey. May, 1974

In March, 1974, the regulations were amended to include provisions for clinic costs. This time the Department concluded that the normal policy of allowing 30 days for comment was "impractical, unnecessary and contrary to the public interest". Again, the amendments became effective immediately.

Then in early April a second set of amendments to the regulations was printed in the **Federal Register**, including some positive changes: a confirmation of the medical rights of participants, a promise of a standard application form, and a guarantee that WIC benefits could not be counted as income under other programs.

But this time the 30 day comment period was allowed, and many alternatives were suggested by those who felt that the existing regulations limited the program contrary to Congressional intent: too narrow a definition of participant eligibility and local sponsor eligibility, and too little flexibility in the content of the food package.

The 30 days passed. So did June and July. In August, James Springfield, Deputy Director of FNS, indicated that the regulations would be signed in mid-August. In early September, Harold McLean, Acting Director

. . . I would like to express my sincere concern that the funds appropriated to explore innovative distribution systems and health improvement potential of special supplemental food programs for nutritionally vulnerable individuals will not be effectively utilized to their maximum potential if inflexible guidelines and limitations are placed on WIC grant applications . . .

Letter to Secretary Butz from
Dr. Neil Solomon, Secretary of
Health and Mental Hygiene, Maryland.
October 19, 1973

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of WIC, said that release was imminent. October, November and December passed. Finally, on January 23, 1975, the new regulations were printed in the **Federal Register** in their final form. There were only minor changes from the April proposals.

The Application Form

USDA has offered almost no technical assistance to potential sponsors, causing confusion in the field and extra work for itself. It did not even follow the normal federal practice of sending out application forms.

To cope with this problem, The Children's Foundation made up a sample application form in July, 1973, based on the first regulations, and sent it out in an information packet. One regional office sent out that form unofficially. California adopted the form officially. Some states designed their own form, others did not. It is hardly surprising that countless applications arrived in Washington incomplete, or that FNS sent out hundreds of requests for additional information. In its own 1974 report[10] it complained about the many lengthy applications and incompleteness of the documentation, "necessitating further work with the applicants". An official form and clear instructions about required information would have spared them this problem and expedited the whole process.

In January, 1975, USDA finally announced the adoption of its standard form "Application for Federal Assistance (Nonconstruction)" for use in the WIC program. The accompanying instructions indicate that states should submit a single combined application for fiscal year 1976, based on their current authorized caseload. Although the adoption of a standard form does clarify some questions, others remain—particularly since the new fiscal year will require new legislation and funding levels.

The Either/Or Policy; WIC and the Commodity Supplemental Food Program

The WIC legislation clearly states that its programs "may be carried out . . . without regard to whether a food stamp program or a direct food distribution program is in effect in such area".[11]

Many areas with commodity distribution programs also had supplemental food programs. USDA gave lowest priority to those areas where supplemental food programs — and thus useful experience and defined need—already existed. Under this absurd policy a huge, sprawling city like Los Angeles was totally disqualified to participate in WIC because the commodity program fed 1,000 mothers and children in Watts. The either/or policy was designed to force a choice, with commodity supplemental the loser.

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In considering applications for the Special Supplemental Food Program for Women, Infants, and Children, the Department has assigned a higher priority to WIC proposals originating in areas where there is no supplemental or food certificate program available . . .

We are approving all completed applications in hand which meet the criteria in the regulations for areas where the Supplemental Food Program and Food Certificate Program are not operating. We expect in the near future there will be a sufficient number of additional acceptable WIC applications from areas without existing programs to freely commit available funds . . .

Therefore, it is unlikely that funds will be available for WIC applications from areas in which existing supplemental or certificate programs are operating . . .

Telegram from James Springfield, Deputy Director of FNS to Dr. Jacob Koomen, State Board of Health, Raleigh, North Carolina. December 5, 1973.

Only after considerable public pressure did the Department change its policy and permit dual operation of WIC and the commodity program. In August, 1974, USDA funded the Detroit Health Department with the guarantee that WIC and the commodity program could operate concurrently. Thereafter USDA gave priority to communities which had recently had to close a commodity program, or wished to convert from a commodity program to a WIC program—but it has never encouraged dual operation.

The Tax-Exempt Ruling Requirement

An example of the kind of unnecessary burden that USDA visited on agencies was the requirement that grantees have a tax-exempt ruling from the Internal Revenue Service. The law, of course, requires that clinics which sponsor the program should be non-profit or public; the further requirement of tax-exempt status was added by USDA.

Lowndes County, Alabama, demonstrates the frustration caused by that policy. In December, 1973, word came that the county's Health Services Association, a privately funded, integrated health clinic, had received $94,000 to start a WIC program the following February. Only days later USDA suspended payment of the grant on the grounds that the clinic had no tax-exempt ruling. USDA rejected appeals to channel the money through a tax-exempt sister organization, or to provide it provisionally during the application process. Thus $94,000 that could have gone to nourish mothers and children in the country's third poorest county lay idle for seven months because USDA refused even to bend this arbitrary regulation.

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Restriction to Clinics with Ongoing Health Services

One of the most indefensible of USDA's policies is the restriction of applications to clinics "with ongoing health services". The origins and rationale of the policy are obscure, since it contradicts both the law[12] and the regulations.[13] The results, however, are all too evident in this example:

> In Lee County, Alabama, a local Head Start program applied for WIC in January 1974. Cynthia Allen, the registered nurse who runs the Head Start clinic, said, "We offer health services and keep medical records as required by the regulations. Pregnant women and infants would be referred to the county health department. We would have liked the county health department to participate directly, but the nurse there refused to so much as refer her patients to us." In the course of applying for WIC, Head Start enlisted wide support, not only from the poor community but from the Alabama Chapter of the American Academy of Pediatrics and from the conservative county medical society.
>
> In August, 1974, the county clinic was revamped. The state health officer, Dr. Ira L. Myers, wrote in a letter to USDA that "as soon as time is allowed for organization, planning and implementation, the Lee County Health Department should have an active, viable health care delivery system and be qualified to sponsor a WIC program . . . the Department is anxious for Lee County to have a good WIC program. We shall be working toward that goal with all due speed."[14]
>
> The Head Start application was rejected a few days later. Eight months later there is still no WIC program, nor any health department application for one, in Lee County.

Keeping Community Organizations in Second Place

Another policy of USDA in direct contradiction of the legislation is its position that only health clinics should be funded as prime sponsors of a WIC program; community organizations are allowed to participate only as subcontractors. There are many communities in which a cooperative venture is desirable: the health clinic providing medical services, certification and evaluation, and a community organization responsible for outreach, the food delivery system and community education. Nothing in the law mandates that the health clinic shall always be the sponsoring agency.

USDA's policy is particularly detrimental in areas where a public health clinic is understaffed or financed, or is simply conservative about extending its range of service. Some clinics are unwilling to undertake the administrative planning required in the delivery system, or are fearful of excess administrative costs. And in some communities, a health clinic does not

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exist; a community group could organize private physicians to supply the health care component.

It may be true that public health agencies have a greater capacity to collect and record medical data on participants, but community organizations may more effectively increase outreach, experiment with alternative forms of food distribution, show sensitivity to cultural problems, and report more accurately about the needs of participants.

There should be no rule of preference. In some cases, a clinic is better able to take the initiative and have the major responsibility, in others the community organization is a more logical choice. USDA has taken an arbitrary and unnecessary view.

Funding Games

USDA adopted another diversionary tactic in mid-1974, when it was being pressed to make and announce grants for the third year of the program. Instead, it made some continuing grants for the first quarter of fiscal year 1975, and wrote in response to a Senate inquiry that it could not do more because funds for the entire year were not yet appropriated.

This was nonsense, because the authorizing legislation specified that in case Congress does not appropriate special funds USDA is to run the program at full funding from another, always available source: special customs receipts.

USDA's action caused enormous administrative difficulties for state and local administrators. In many instances increased food costs and participation waiting lists made fiscal year 1974 budgets inadequate and impractical. Administrative work for the state health departments was doubled: they were forced to issue one set of budgets for the first quarter of fiscal year 1975, and then later reissue budgets for the remaining three quarters.

The Cost of Keeping Evaluation Data

The problem of medical evaluation had further repercussions in 1974. Twenty sites had been chosen to participate in the major university evaluation process; all others were to collect data for a so-called "partial evaluation". The first set of regulations, published in July, 1973, made this obligation plain. Local sponsors therefore calculated their clinical budgets on the basis of a 20 minute examination and certification of participants at each visit, plus another 30 minutes to take measurements and make tests which would serve the evaluation requirement. Clinics began operation on this basis, many of them keeping accurate records although USDA had not yet sent out an official record-keeping form.

In the spring of 1974 the Department found itself still without a contractor for the partial evaluation, and so decided to eliminate the cost of this medical record-keeping from the allowable cost reimbursement. Clinics were surprised and angry to learn that USDA was changing the ground rules. State officials protested vigorously. First, many of them had already incurred expenses for several months in good faith and did not appreciate being penalized for prompt and efficient activity (Vermont, for example, had trained clinic personnel, encouraged a 90 percent voluntary participa-

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tion by patients, and spent $4,825 on base data from 2,500 women and children).[15] Second, most believed in the value of professional evaluation and could not understand why USDA would drop it.

Nevertheless, USDA never did find a contractor—although they had nearly drowned the program in talk of evaluation requirements during its first year—and the final regulations of January, 1975, leave it to each state to summarize the "benefits and disadvantages" of WIC as it wishes.

Access to Information

As the program proceeded through 1974, another serious problem arose at the national level: a lack of information about what actually was happening to grant applications, and information about the total expenditure level. Since USDA had final approval of applications, and frequently held them for months at a time without revealing their status, state and local officials found planning extremely difficult. In July, 1974, The Children's Foundation reached an exasperated decision to file a Freedom of Information action against the Department, which forced them to open their files and procedures to public inquiry. The Foundation was then able to document how much grant funding was still available (which the Department had said did not exist), to compile a status report on applicants, and to calculate overall need and participation rates.

> The agency and all local agencies participating in the WIC Program have cooperated to the best of our ability with every program regulation, every change in the program regulations, every requirement for additional reports and information, every administrative and financial constraint and every change in allowed food items.
>
> If this program is to continue we must have the support and cooperation of the United States Department of Agriculture.
>
> *Letter from Illinois WIC Administrator to Regional USDA Office. July 10, 1974*

In summary, the program has been managed by an agency that never wanted or believed in it, and had no genuine desire to study and learn about the most effective methods of operation. Its policy was one of limitation and containment. The result was inevitably to delay and curtail the effectiveness of an important public program.

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THE STATES: A MIXED RESPONSE

Without leadership or instruction from Washington, state health departments undertook their part of the administration of WIC with varying degrees of success. Since the states had little guidance on application process, timing of grants, voucher system design, medical rules, or data collection, it was certainly not surprising that some of them gave little technical assistance to possible sponsors.

Nevertheless, some states have demonstrated an outstanding response to this opportunity:

- Vermont organized a statewide home delivery system, contracting with more than 40 dairies to deliver not only milk but the whole food package to the remotest parts of the state. Participants receive their food order forms at one of 12 locations, and the dairies deliver on an agreed schedule. This innovation has not been free of troubles, but demonstrates the kind of experiment and adaptation the program was meant to encourage.

- Arizona had already operated a nutrition assistance program for several years in most of its 14 county health departments, which included training indigenous personnel to help with advice, referrals and nutrition education. They were able to integrate the WIC program into this sytem, adding the essential component of free food to those in need. By now all fourteen counties participate, and 8 of 10 Indian reservations. The Navajo reservation, which had the option of joining either the Arizona or New Mexico system or dealing independently with the federal government chose to apply as a part of the well structured Arizona state system.

- California mounted an active program; its state WIC staff travels extensively, visiting the 36 local projects routinely twice a year. They have also held two statewide meetings to discuss administrative changes and policies.

- In June, 1974, Montana submitted a state WIC plan based on the experience of two previously operating projects. The plan encompasses 11 counties and five Indian reservations, covering 66 percent of the state's population—and providing another demonstration of effective outreach to rural populations.

- In Washington there are WIC clinics in all but eight of the 39 counties; the state hopes to reach every county within the next two months. Locally, WIC operates from hospitals, county public health facilities, Indian health service centers, and migrant health centers. Washington's program has a unique feature: a non-profit corporation acts as a fiscal link between

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local clinics and the state agency. The corporation developed and now monitors the statewide voucher system, provides technical assistance to local clinics, and assists the state in overall evaluation. The state health department concentrates on the substantive health and nutrition issues.

- In Minnesota, initial experience with WIC has persuaded a state legislator to propose a state supplemental nutrition program which would work in conjunction with the federal program.

Some states, however, resisted the program (or some of the applicants) for reasons of their own:

- A few states do not favor applications from community clinics connected with poverty organizations. In Nevada, Operation Life, a non-profit corporation providing health and welfare services had to pressure for weeks before the state would forward its papers to USDA. The Hill Health Center in New Haven, Connecticut sent its application to the state health department by the first August 15th deadline, but it did not reach Washington until three months and three deadlines later. The state never notified the center about the delay. In Mississippi, an application from a black community-controlled clinic, The Voice of Calvary Health Center, sat for months without action from the state, in spite of complaint letters to Congress, the press, USDA and the U.S. Commission on Civil Rights.

- Some states—acting without sufficient instruction from USDA—have circulated misinformation. The Director of Nutrition in Ohio, for example, announced that bloodtests would be a prerequisite for WIC food until an outraged local committee forced state officials to conform with federal guidelines on the Protection of Human Subjects.

- In Oregon, a legislative Emergency Board voted in January, 1974, to return a $700,000 state grant, fearing that the time was too short to gear up the five local projects funded by USDA, and that the state would be obligated to underwrite some administrative overhead at the end of the fiscal year. Only a concerted campaign by a local committee got WIC started in Oregon, where programs are now running beneficially with wide public support.

- Some states did next to nothing to publicize the program; Virginia is probably the most flagrant example of state indifference. The state health department never informed coun-

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ty health units or hospitals, nor any other potential sponsors. In February, 1975, 30 months after the first applications began to arrive at USDA, the first one from Virginia reached its regional office. There are today no WIC programs operating in that state.

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The eradication of infant and maternal malnutrition can be relatively inexpensive. We can give every infant adequate nutrition and a chance to realize his or her physical and mental potential, or we can ignore the problem and pay the price in lives dwarfed, hopes unfulfilled and society damaged. It's up to us.

Merritt B. Low, M.D.
President-Elect, American Academy of Pediatrics
in Parents Magazine, March, 1975

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V. Local Programs: Progress and Problems

The 335 WIC programs now operate in 48 states. They are sponsored by public health departments, hospitals, and private non-profit organizations. They range from small programs involving 100 participants to ones as large as 12,000. California, New York and Texas have the largest number of projects.

All the programs offer valuable experience from which lessons can be drawn. The descriptions that follow single out some of the typical and less typical examples.

In Georgia

By far the majority of WIC programs around the country are sponsored by city or county health departments. For example, eleven of the thirteen sponsors in Georgia are public agencies.

One, the Northeast Health District, encompasses ten rural counties where many families have no transportation, refrigeration or indoor plumbing. Eleven clinic sites within the district reach about 1,000 WIC participants. A special grant from the March of Dimes adds money for a full time nutritionist who coordinates the work of clinic staffs. The University of Georgia and the Agricultural Extension Service supply additional nutrition education resources. Women in this area who had meat perhaps once a week, who never drank milk or fruit juices, and who could afford eggs only once or twice a week, can now eat a protein, iron

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and vitamin rich supplement when they are pregnant, and give their children a chance for a healthy start in life.

In New York

Two New York projects illustrate how programs can adapt to different local situations.

The Sunset Park Family Health Center serves about 10,000 in an urban, predominantly Hispanic area in Brooklyn. A study done at the Center in 1970 revealed that 60 percent of the infants in the neighborhood suffered from iron deficiencies. In that year, the Center could dispense advice about curing the problem, but nothing else.

New York State policy is that applicants develop their own delivery systems so when the Sunset Park Center decided to apply it approached a neighborhood Coop about supplying the WIC foods. The Coop agreed to open a new location just six blocks from the clinic which issues non-negotiable vouchers that participants can redeem only at the Coop.

For working women in the neighborhood the closeness of the food supply to the clinic means that they can readily participate without adding to their daily transportation requirements. For the whole neighborhood, the new Coop provides an additional benefit. For the clinic personnel, WIC foods mean that they can combat nutritional deficiencies effectively rather than just talk about them.

Miles from this urban environment, the North Country Children's Clinic opened in 1972 to serve children through school age, introducing the idea of preventive health care to families in four rural counties of upstate New York who had previously come to clinics only in emergencies. When the Clinic added a WIC program in April, 1974, they coped with the problem of distance and transportation by enlisting the cooperation of over 40 area grocers. Today the program reaches over 1,000 women and children.

In California

In 1968 the northern part of Santa Clara County had limited public health service. Some Chicano families in Alviso organized to build a clinic themselves, and then succeeded in getting HEW funds to operate and expand it. They welcomed the chance to add WIC services in early 1974, and have concentrated on nutrition

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education. They use a separate building behind the main clinic with a room for voucher distribution and another for classes. They hired a nutritionist to conduct classes during the day and in the late afternoon for working participants. Orientation classes are held for new participants to explain how to use the vouchers as well as other health services of the clinic. Since the program reaches both Anglo and Chicano families, classes are given in both Spanish and English on topics ranging from buying tips to the value of certain foods.

The history of the Family Health Foundation of Alviso as well as the interest generated by the nutrition classes led naturally to the formation of a WIC advisory board. Ten participants now publish a monthly newsletter and relay ideas to the staff.

In Nevada

In Las Vegas one WIC program is sponsored by Operation Life, Inc., a private non-profit organization organized by the county welfare rights group. It is a unique project involving many low-income individuals in activities which greatly affect their lives.

Like many other clinics they administer both WIC and an Early Periodic Screening Diagnosis and Treatment program from HEW funds, thus providing a combination of nutrition and health care that is becoming very effective. The staff of the clinic includes nine medical professionals and paraprofessionals and more than 20 outreach workers.

In Massachusetts

Several doctors in Cambridge organized another variation of WIC sponsorship: a local non-profit corporation affiliated with the Cambridge Hospital. The Cambridge Supplemental Food Program, Inc. contracts with a local bank for data processing, payroll preparation and other necessary financial services. The local sponsor deals directly with the state health department, rather than working through the city health services.

The city, however, was responsible for five local health stations in public schools which ran a lead poisoning prevention program and dispersed general pediatric care in connection with the same hospital. WIC was integrated into this neighborhood health service with great success.

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In Arizona

Most WIC programs on reservations are sponsored by the Indian Public Health Service; however, on the Papago Reservation in Arizona the tribe sponsors the program.

Many Papago families live in the small towns of Sells, San Xavier and Santa Rosa. Others live in villages scattered throughout the 260 square acre reservation. Soon after WIC opened in January, 1974, more than 60 children arrived on one day at the Indian Public Health Service Hospital in Sells to be screened. The WIC staff realized that the hospital could not accommodate the hundreds of participants who were coming, so they decided on a decentralization of their service. At 22 mini-clinics throughout the reservation they weighed, measured and interviewed potential participants. Then they continued the outreach: five aides travel to more than 30 villages each month to distribute vouchers. In towns, participants can receive their vouchers at other centers.

The Papagos elected to join the Arizona state voucher system because of its efficiency and flexibility. Papago families can redeem their vouchers for WIC foods at the six trading posts on the reservation or at the nearby grocery stores off the reservation. Today the year-old WIC program has given hundreds of Papago families a chance to take good nutrition seriously.

NOTE: On April 1, 1975, after the report had gone to press, USDA announced 45 additional grantees. See Appendix E.

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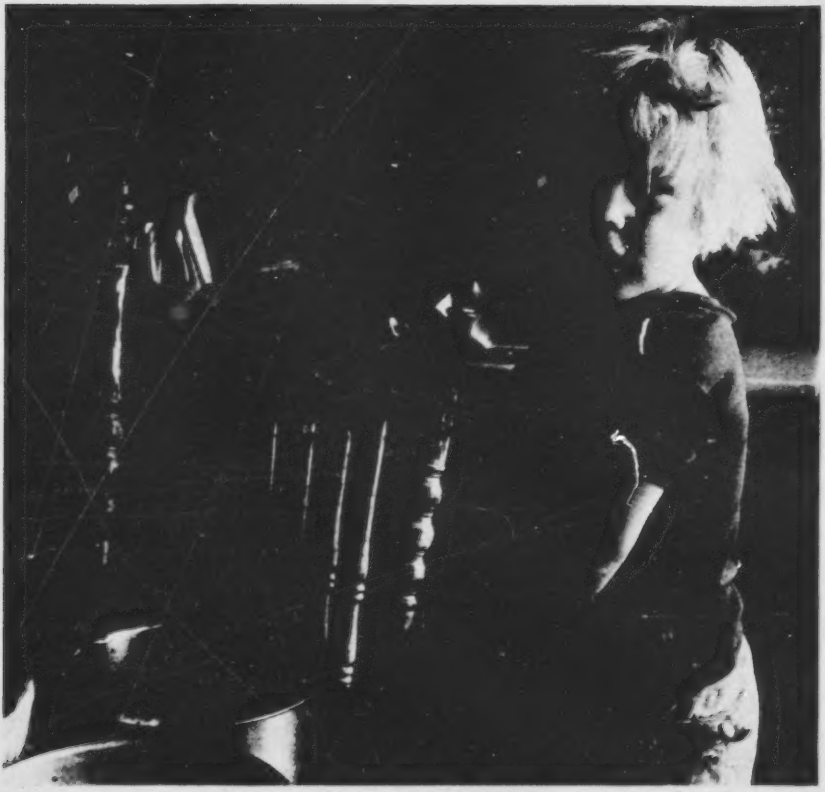

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America's prosperity is built upon its people—the most productive and creative in the world. The cost in loss of human potential and productivity is incalculable for each young mind that develops without proper nutrition. . . .

Senator George McGovern
Preface to Committee staff report March, 1975

VI. Lessons From the WIC Experience

Although the real operation of WIC has only unfolded for about a year—a period far shorter and less illuminating than Congress intended—there is nevertheless a fund of information and experience about the issue which Congress originally proposed: can a system of distributing protein and vitamin rich food to low-income mothers and children make a difference in their nutrition and the incidence of physical and mental handicaps among the children? .

WHAT HAVE BEEN THE MEDICAL AND NUTRITIONAL BENEFITS?

No doubt exists about the nutritional needs of the people WIC is designed to serve, and about the desirability of intervening in the cycle of poverty by providing extra food. Congress has already heard evidence through the testimony from the research program at St. Jude's Hospital in Memphis that distributing supplemental foods makes a measurable difference in the size, weight and health of small children in low-income families.[16]

Nevertheless, the WIC program was supposed to include further evaluation during the pilot phase of the program. The findings of the major medical evaluation for which USDA contracted with the School of Public Health at the University of North Carolina cannot be judged until they are submitted in October, 1975. The original partial evaluations at other sites have been cancelled. But preliminary information received from state and local administrators documents important results:[17]

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- WIC has improved attendance at health clinics: programs in Apache County, Arizona and Livingston County, New York report attendance at their prenatal clinics has doubled since WIC began.

- Women are coming earlier in their pregnancy for health and nutrition care: Donna Schemanske, California's WIC Director, states that there has been a noticeable increase in the number of women who see a doctor during the first trimester of pregnancy.

- Patients are keeping appointments more regularly, more comprehensive and earlier care is provided for children who formerly did not come to the clinics: in Bowie County, Texas a baby participating in the WIC program was diagnosed as having a congenital lung disease. The Program Administrator feels that this might not have been detected at this early age had the baby not been participating in WIC.

- Texas reports increased trust and confidence about health services because food as well as advice is available.

- North Carolina states that they have found higher birth weights in infants born to women who had previously produced low birth weight babies.

- Delaware indicates that hematocrit counts have improved, and medical costs have lessened because of better health of individuals.

- Kenneth Ball, Director of the WIC Program in Coffee County, Alabama, explains that his clinic has seen remarkable improvements in the health of extremely anemic kids within four to five weeks.

- Dr. Robert Hastedt, Health Commissioner of the Tuscarawas County General Health District, Ohio, states, "During the enrollment of infants and children in the spring of 1974, over 30 percent were discovered to have low hematocrits. The percentage of low hematocrits in pregnant and nursing mothers was 34 percent. Revisits to the clinic six months following issue of the food supplement revealed the hematocrits had improved in 90 percent of the participants."

- Dr. Ralph Gofstein and Suzanne Van Vechten of the Stamford, Connecticut, health department report: "Some of the initial

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medical evaluation has already appeared. . . . We have defined iron deficiency anemia for children as those having hemoglobins below 10 point; for women, hemoglobins below 11 point. At their initial interview, 11 percent of the children and 19 percent of the women were anemic. In comparing the intake data with data obtained on re-evaluation visits six months later, there has been a decrease in incidence of iron deficiency anemia." Dr. Gofstein and Ms. Van Vechten also state, "There are a number of secondary benefits from the WIC Program including expanded utilization of other health services and the opportunity to improve screening for lead paint poisoning, hypertension, sickle cell trait and disease and immunization status as well as eligibility for Title XIX services, particularly screening and diagnostic ones."

- The Louisiana administrator of nutrition programs testified that:

A preliminary review of data shows that the nutritional status of WIC participants has improved. Maternity patients are seeking medical care earlier in pregnancy and attend maternity conferences more frequently. Mothers are prompt in seeking health care for their infants and are keeping more appointments for services for infants and children. Immunization rates have improved. . . .

Our nurses, who have worked in the same area for many years and know generations of the same family, say that the difference in appearance and development between older siblings, when they were infants, and the infants and children who have been on WIC since the beginning of the program is very pronounced.[18]

However incomplete the documentary evidence so far, the comments of the National Institute of Child Health and Human Development in 1969 remain valid:

It is neither necessary nor desirable to delay establishment of appropriate programs to improve nutritional status and eating practices of mothers and infants until this research is completed. Existing information demonstrating the benefits of good nutrition on improved health and physical growth already thoroughly justifies such efforts. Possible long-term benefits to intellectual ability and performance merely make the need more apparent and the solution more imperative.[19]

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WHAT HAVE WE LEARNED ABOUT DELIVERY SYSTEMS?

USDA regulations assign the choice of delivery systems to the states. Most have designed a statewide system; a few left this to the local sponsors. New York has probably the most variety; in New York City alone there are 14 different systems, but the state health agency is now trying to establish a uniform method.

The most common delivery system adopted by states is non-negotiable vouchers. A few worked with banks to design a system of negotiable checks. Some designed home delivery or direct distribution systems.

Generalizations are difficult, since the success of a program often depends more on the local implementation than the chosen mechanism. But some useful observations about the merits and defects of each system can be made.

Vouchers and Checks

Vouchers or checks redeemable at grocers have some common problems. Often the paper is good for more food than can be conveniently stored (for example, two gallons of fresh milk) or carried (for example, 31 cans of infant formula, weighing 25 pounds). Another problem with printed vouchers is that some states simplify them by printing only one of several food choices on them, instead of allowing the alternatives and substitutions permitted by the regulations (for example, only dried milk, or only whole milk). The paper work is clarified, but participants are denied what little flexibility exists in the food package.

Checks apparently have some major advantages over vouchers. One is that they are more acceptable to grocers, who can deposit them directly like any other check rather than extending thousands of dollars of credit to state health departments while vouchers are being reimbursed. The best voucher systems work promptly, as in Texas, but some take six to eight weeks for reimbursement. Real or anticipated lags of this kind cause grocers to leave the program, or to never join in the first place.

Another advantage of checks is that they seem to be far more acceptable to participants. A check is a typically middle class medium of exchange; vouchers, purchase orders and coupons are for poor people. As long as government subsidies are a necessity, as long as "funny money" is the order of the day, it is better to have it in the form of checks than vouchers.

However, some preliminary reports suggest that checks are a more expensive system to operate. This may be true since some of the work of processing them is shifted away from the grocer, who tallies each voucher in periodic requests for reimbursement without compensation, to the bank which charges for this service. Overall cost, therefore, may be an obstacle to wider adoption of check systems.

Finally, there are a few states which report that the use of checks is prohibited by law.

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Home Delivery Systems

Vermont's home delivery system in rural areas uses more than 40 dairies to deliver all the WIC foods. The dairies buy on a wholesale-cost-plus-commission basis those foods which they do not normally stock; the infant formula is bought and sent to the dairies on a wholesale contract between the state and the manufacturer. The Vermont State Health Department reports some serious disadvantages with this system: they are heavily burdened with paperwork, participants have no choice and sometimes suffer from bad service from a particular dairy, and there is not enough dairy capacity in the state to expand the program. On the other hand, there are major advantages: WIC reaches people who have no transportation, the state is certain that the right food is used, and people use the program who would object to a coupon program. Vermont will add an alternative voucher coupon system this spring to meet some of their problems: participants will have a choice, the program will be able to expand, and the paperwork will be processed by a bank on contract.

There are several examples of urban home delivery systems that seem very positive. In Dallas one dairy under contract buys and delivers all the food once a week on a set schedule. Participants pick up their order forms once a month at the clinics, and seem happy with the delivery system. The dairy objects to the delay in reimbursement; a cumbersome system of multiple approvals of reimbursement forms makes it much longer than the prompt computerized voucher reimbursement that other Texas communities use.

In Atlanta there are two home delivery projects which are apparently working well enough that a new third project chose to join this system rather than use the state voucher system. Clinic staff report good cooperation from the dairy and that the participants like the arrangement. The Southside Comprehensive Health Center medically certifies participants every six months at the clinic, and issues order vouchers every month or two.

Pierce County, in Washington, uses an interesting combination of nutrition aides and home delivery. The sponsoring agency, The Mary Bridges Children's Center, has 20 aides who are usually indigenous to the area and have a close understanding of the families they will serve; they make home visits, give nutrition and health advice and make referrals. A local dairy is under contract to deliver milk, eggs and cheese to the WIC participants' homes. Some food can be picked up at the Center one day a week. The rest of the formula, cereal and juices are delivered by the nutrition aides on their routine visits. This combination of outreach, home delivery and nutrition education seems particularly productive.

Direct Distribution from Warehouses

A few states have direct distribution systems, but the evidence so far indicates that these are less effective. One direct distribution system near Chicago, Illinois, was begun because there were no major retailers within

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the geographic boundaries. The program reported serious inconvenience for participants, and asked to change over to a voucher system.

In Mississippi the state purchases the food and ships it to the four sponsoring centers. The first food supplier could not guarantee all the products, and a second company replaced it. But apparently there are still occasional shortages of available foods, and the state reports inventory and bookkeeping problems. The problems mounted so rapidly that the state closed the warehouse in Jackson for 10 days last summer.

On the other hand, the warehouse system running for some years at St. Jude's Hospital in Memphis—a different program on which WIC was based—seems to function very well.

In summary, no system is entirely free of disadvantages, and none has been entirely discarded. A great deal depends on the skill with which any system is administered. States will want to look at comparative cost figures when the national evaluation is available. In the meantime, more experiment and study seem called for.

WHO SHOULD BE ELIGIBLE TO PARTICIPATE IN THE PROGRAM?

The present law and regulations limit eligibility in WIC to those who:

- reside in an approved neighborhood;
- receive health care at an approved clinic;
- meet age and pregnancy status requirements;
- are eligible for free or reduced cost medical care; and
- are certified by professional staff as needing extra food.

The program gives professionals in local projects the right to determine who shall participate within these broad guidelines, and the need factor, or the definition of "at nutritional risk" has been interpreted differently in different parts of the country.

In Charleston, South Carolina, a program with an authorized caseload of 1,800 was operating after five months with only 300 women and children participating. The local director insisted that the program should be remedial, not preventive; he limited his certification to those with severe anemia or medical deficiencies. Eleven months after the start of the program, in January, 1975, participation had increased to 1,001, but 45 percent of eligible women and children are still without supplemental food.

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Nutrition professionals agree that low-income pregnant women and their infants are by definition "at nutritional risk". The WIC legislation is specifically worded to apply to low-income populations; its intent is preventive. The practice in all local clinics should be consistent, and inclusive.

> Our studies here have shown that the population at large in our study area is anemic and malnourished. There are some who are worse than others, and they must be hospitalized. But they're all affected.
>
> It's an iceberg phenomenon. If you can find three cases of smallpox, you vaccinate everybody. If one person comes up with polio, you can pretty well expect the virus is with everybody.
>
> And you don't treat polio by building big clinics full of iron lungs. You treat polio by preventing it.
>
> I say that someday malnutrition must be faced by our people as any other medical problem. It is not a simple disease to cure, but it is easy to prevent.
>
> And you prevent malnutrition by feeding people.
>
> *Dr. Paulus Zee*
> *Memphis Commercial Appeal*
> *December 27, 1970*

A second problem of eligibility relates to the determination of low-income status. In the present regulations the language calls for a determination that applicants qualify for free or reduced-price care at the clinic. In state-sponsored clinics in 26 states, this means that the family must be on welfare. In such clinics in the other states, there is in addition to the welfare category a category called the "medically needy"—a group defined differently in practice in various states.

Thus, the qualifications are inconsistent and bear no rational relation to need. Funds are allocated and food is distributed according to the peculiarities of Medicaid eligibility in each state. There should be instead a federal minimum standard for income eligibility for WIC.

WHAT ABOUT ADMINISTRATIVE COST?

The WIC legislation limits administrative costs in any local program to not more than 10 percent of the federal grant. The state has the responsibility of dividing the administrative funds between its own needs and those of local sponsors. Experience in every state reveals that WIC can never pay its way with a 10 percent administrative allowance.

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USDA regulations further complicate the problem by requiring that the administrative allowance be based on 10 percent of incurred food costs. This has several negative results.

- It means that an administrative budget can change every month.
- It forces projects to maximize their food costs. For example, a state with a centralized distribution system may buy from a wholesaler at retail prices in order to keep its food costs sufficiently high to support the rest of the operation.
- It forces programs to operate on a limited budget during the crucial first months when participation is lowest. The irony is that many programs cannot reach caseload without administrative expense, but cannot spend more money until the caseload is reached. The lack of adequate start-up funds multiplies problems; The WIC director in Corpus Christi explained: "lack of start-up costs caused the program to be implemented more slowly . . . maximum effectiveness was impeded for at least three months". Many WIC administrators advocate a special initial budget up to two months of the overall program grant.

Even with a more sensible basis for determining the percentage, a 10 percent allowance would be insufficient. Small programs have particular difficulty; they are penalized because they do not generate enough administrative funds to support an effective program.

The United Indian Health Services, Inc. of Trinidad, California, reported that only a third of its administrative costs are covered by the WIC budget. The Seattle-King County Health Department estimated that WIC funds pay only 30 percent of its administrative costs. The Sunset Family Health Center of Brooklyn, New York, reported that 55 percent of its costs are absorbed by the health center. The State of Vermont WIC programs were in operation six months before administrative costs fell to 10 percent; during this period the actual cost exceeded the allowance by $44,000. In Kentucky, WIC paid for only half its administrative costs in December, 1974; the rest came from state and local funds.

What this means is that some areas cannot undertake a WIC program because there is no facility willing or able to provide the umbrella. In Florida, the rural counties with the most depressing maternal and infant morbidity and mortality rates did not apply because they could not handle the program.

What it also means is that local sponsors cannot mount the kind of education and outreach components that would make WIC a truly preventive nutrition program. Distribution of food without nutrition education for the women who come to the clinic is wasteful and shortsighted. State and local administrators universally agree that nutrition education must be funded if the full potential of the program is to be reached. Funds for outreach are also needed to insure program success; the low participation rates

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in many areas are a direct result of not having sufficient staff and funds to publicize the program among potential participants.

> The WIC foods themselves offer short-term benefit; the accompanying education will contribute to life-long health and wise buying practices. We cannot afford to disregard this opportunity to teach health, nutrition, and consumer awareness to an aroused audience. Our WIC participants ask pertinent questions while their blood is being drawn and their vouchers filled out. If we ignore them, we will perpetuate their dependence on our handouts.
>
> *Letter from Chief of Nutrition Services, Arizona, to Clerk of House of Representatives May 7, 1974*

The 10 percent allowance is unrealistic. It needs to be doubled or tripled, and to include specific support for start up costs, nutrition education and outreach. A higher administrative percentage would enable moderately funded health facilities in the most depressed areas to apply.

> It is most important to provide the benefits intended at minimal cost, but with the assurance that clinics do not hesitate to get involved for the lack of operating cash. Administrative allowance should be based on number of participants or a fixed percentage of total budgets: the smaller project to receive a greater percentage of cost per participant than the larger ones. Start-up costs should be allowed also on one of the above bases, which must be in addition to routine monthly operation.
>
> *Letter from Director Bureau of Nutrition, and Nutrition Program Administrator, New York. March 7, 1975*

WHAT ABOUT THE FOOD PACKAGE?

In an effort to prescribe the foods that would have the most nutritional benefit for pregnant women, nursing mothers, infants and children, the WIC regulations list specific kinds of milk, cereal, juice and eggs for each participant.

Many state and local officials have pointed out difficulties with these restrictions.

- Cultural and ethnic preferences and habits can produce resistance to some of the items. For example, milk and cheese are

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not traditional Apache foods. In some Southern states iron-fortified buttermilk or chocolate milk would be more acceptable. Alaska suggests an emphasis on hot cereals, but requests a possible substitution of canned tomatoes and citrus fruit to supply Vitamin C.

- Another problem stems from allergies or medical problems. Many nutritionists want to substitute soy products for cow's milk. Arizona reports that since anemia is a major health problem, they want to use more meat, beans and green vegetables.

Because of all these regional and ethnic variations, a better solution would be to let states design at least half of their own food package.

> First I would like to say that the WIC Program was the best thing that ever happened to us. We have been in the program since June 7, 1974, and have had no problems till my 6 1/2 month daughter went on whole milk . . . she can not drink formula. So now we can not afford to feed her milk. . . .
>
> I can not understand why the regulations were changed in the first place.
>
> *Letter from a WIC participant*

WHAT ABOUT PARTICIPATION RATES?

When local clinics apply for a grant, they estimate how many people in their area are eligible, and how many they have the capacity to serve.

USDA usually authorizes the maximum caseload estimated by a local sponsor when it makes a grant. The total caseload nationally is now 635,415 women, infants and children—but only about 65 percent of them are being reached as of last October.

Within that average hide wide state variations: last October, Pennsylvania projects were serving 30 percent of their caseload, while Kentucky projects served 100 percent of theirs. In December, of those states reporting 19 were serving 80-100 percent of their authorization, 17, 50-80 percent, and eight less than half of their caseload.[39]

The reasons for low participation are varied. Some local administrators are simply indifferent, or overburdened, and do not bother to seek out eligible patients. Some are hampered by inadequate outreach funds; they cannot spare the staff or time to publicize the program and make it understood. Some projects are in facilities too small to accommodate more patients. Some professional staff take a narrow view of eligibility and will not certify participants on a preventive, inclusive basis. New projects frequently take several months to get their caseloads up to maximum.

On the other hand, some projects are overextended and have long waiting lists because they underestimated the need, or simply do not have

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facilities to serve large numbers. Projects at the Bangor, Maine Health Department and Presbyterian Medical Service, Cuba, New Mexico, moved quickly to 100 percent service.

A recent policy change at USDA will smooth out some of the problems. State officials may now shift caseload assignments from project to project within the state, adjusting to temporary problems or inaccurate estimates.

Although participation rates do reveal a rather slow start for many WIC programs, as other problems of administration are corrected it can be expected that higher participation rates will result.

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This program must be continued and expanded so that more women and children can avail themselves of these necessary foods.

Let us spend our money wisely. Let us spend it in a positive constructuve manner that helps infants grow into healthy children and adults. Let us take the initiative to prevent sickness and deformity, rather than spending money in later years to cure or simply maintain an illness or retardation that we perhaps could prevent now.

Congressman George Miller
Congressional Record
March 24, 1975

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VII. Will The WIC Program Continue?

This spring Congress is studying two and a half years of experience with WIC in order to decide on its future. There is no doubt that the evidence calls for continuing WIC in an improved and expanded form.

There are today 335 WIC programs in 48 states with an authorized caseload of 635,415 women, infants and children. The annualized budget for these projects is about $200 million. In addition, the Commodity Supplemental Food Program serves 130,000 persons in 106 projects in 21 states.

WIC has only begun to meet the need. Some 4.6 million women and children are eligible—are "at nutritional risk"—in America. WIC and the commodity program between them are reaching only about 16 percent of this population; the remaining 84 percent have no access to supplemental foods at all.[21]

A dramatic illustration of unmet need is found in three Southern states, Mississippi, Alabama and Georgia, where there are 28 counties in which more than 50 percent of the population is below the poverty level;[22] WIC clinics operate in only three of these 28 counties. In Illinois, the state WIC director estimates that 1,000,000 people qualify; the current state caseload of 16,140 reaches only a tiny percent of that need.

And among those who already need nutritional help, the economic situation of 1975 has created an even more desperate need. Everyone suffers in times of high inflation and high unemployment. But national statistics translate into a disaster for families already in poverty.

- Poor people use a much larger proportion of their limited budget for food purchases (as much as 61 percent for the lowest income group, as little as 12.2 percent for the highest), according to the Bureau of Labor Statistics.[23]

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- Food prices have risen much more than prices of other items in the consumer price index.
- The poor cannot economize by eating less expensive kinds of food, as they already use the cheapest items in the market basket.
- The price of the cheapest food has risen more rapidly than the price of more expensive food. For example, from 1970 to 1974 hamburger increased 60 percent, steaks 39 percent; dried beans increased an astonishing 256 percent; margarine went up 63 percent; but butter only 9 percent.[34]

Thus, the purchasing power of the poor, and the ability of poor families to maintain a nutritious diet, are declining disastrously. Even with an increasing federal effort through welfare and food programs to solve problems of hunger and malnutrition among the poor, we are falling further behind.

The question is not whether the national commitment to reach women and children at nutritional risk should continue, but rather what form it should take.

Some of the official evaluation of WIC is not yet available; the Bureau of Standards report on operations is due in June, 1975, and the major medical evaluation will not be public until October. But the unofficial returns indicate widespread effectiveness and support for the program.

The Governor of Tennessee has written to USDA to state that he is "well pleased" with the WIC programs operating in his state. The Nutrition Committee of the American Academy of Pediatrics met in February, 1975, to review the federal child nutrition programs and concluded that "significant harm" would result from their termination. They stated that:

> "Everyone would welcome social changes which accord all people the opportunity to provide for their own needs. The present status of many people in major cities and rural areas precludes this. Food supplementation is a necessary support to people presently unable to achieve this goal."

At hearings in March, 1975, before the House Subcommittee on Elementary, Secondary and Vocational Education, Gabriel Stickle of the National Foundation—March of Dimes testified that:

> It is our view that the Special Supplemental Food Program for Women, Infants and Children represents the first significant effort by the federal government to improve the quality of life at birth and during early childhood by reinforcing sound advice about maternal and infant nutrition with the food required to make that advice really effective. We urge the Committee to enact

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legislation which would continue, expand and improve that program as a permanent adjunct of maternal and child health. The cost of providing this program is modest in comparison with the benefits which accrue not only to those served directly but to all citizens who bear the infinitely larger costs of mental and physical disability due to maternal, fetal and infant malnutrition.[25]

The annual meeting of the Association of State and Territorial Nutritionists endorsed WIC and set up a special task force to follow its progress. At the House of Representatives hearings in March the Acting Commissioner of Health in Minneapolis expressed strong support for WIC, and the administrator of the Louisiana Nutrition program stated that "WIC is a very important component of our health services". Participants, state and local WIC directors, as well as national and professional organizations support the continuation and expansion of the WIC program.

> I have been informed the WIC program may be cancelled. It seems to me that a program intended to insure that children under four get the proper food they need shouldn't be tossed aside without a fight.
>
> I have two little girls one two years old and one two months. I received the WIC program for myself while I was pregnant and I feel it was partly responsible for me having such a healthy baby. I feel sorry for other mothers-to-be who won't be able to give their unborn baby as good a start in life because the program was cancelled . . . .
>
> *Letter from a WIC participant*

But the Administration does not agree. President Ford's budget request for fiscal 1976 proposes new legislation to replace the child nutrition and feeding programs by a block grant to states totalling $1.7 billion. This entails cutting back existing programs nearly $700 million.

Two special provisions of the budget proposal would seriously undermine WIC. First, block grant funds could only be spent on children up to the age of 17, thus eliminating nutritional supplements for pregnant and nursing women. Second, a state's formula for funds would be calculated on the basis of numbers of children between one and seventeen years old; thus, if a state wished to serve infants it could only do so at the expense of another age group. And of course there would be less money to serve any group.

Regardless of the outcome of the Block Grant proposal in Congress, the Administration still intends to terminate WIC altogether. Recent testimony of Edward Hekman, the Food and Nutrition Service Administrator, to the House Agriculture, Environmental and Consumer Protection Appropriations Subcommittee makes clear the Department's view that "target groups served by these [child nutrition] programs can satisfy their needs through the Food Stamp Program in their homes".

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> Being in the financial difficulties that I find myself, I don't believe that I could adequately supply so much of the nutrition that is needed for normal growth. I know juice is better for my children than koolade and four glasses of milk is so much better than one ....
>
> *Letter from a WIC participant*

Fortunately, the Congress does not share the Administration's indifference to infant and maternal nutrition. The Senate will hold additional hearings in April, and bills have been introduced in both the House and Senate to extend and increase the funding of a Supplemental Food Program for Women, Infants and Children.

Before the expiration of WIC at the end of June, 1975, a renewed and improved program will in all likelihood be put in place.

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From a practical viewpoint, we would point out that malnutrition leads to social and economic costs far beyond the expense involved in these programs. From a humane viewpoint, we should remind ourselves that, while federal programs may be expandable, our children are not.

American Academy of Pediatrics
December, 1972

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VIII. The Children's Foundation Recommendations

The Children's Foundation has worked closely with the WIC program for nearly three years. From hundreds of visits and consultations with local programs, we have developed a series of recommendations for improving WIC's operations.

When we were requested by the Senate Select Committee on Nutrition and Human Needs to submit legislative recommendations, we prepared the following suggestions. They have been circulated to all local programs, and represent the best advice we have been given by state officials, local sponsors, and participants.

There is a clear public consensus **that WIC should be continued on a permanent nationwide basis.** Health facilities have proven that a supplemental nutrition program can be administered, and participants have found that the program does make a difference in their health and the health of their children. Renewed legislation and administration of WIC should, however, include these changes:

Authorization

EXTEND THE PROGRAM FOR FOUR YEARS AT A TIME

This will provide for smoother program operation and continuity, better state planning, and less costly administrative uncertainty.

INCREASE THE FUNDING LEVEL RAPIDLY UNTIL IT IS SUFFICIENT TO SERVE ALL THOSE ELIGIBLE

As of January, 1975, the current annual cost of WIC was just under $200 million. A new authorization for fiscal year 1976 should be at least $300 million.

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APPORTION THE MONEY AMONG STATES ACCORDING TO THE NUMBER OF ELIGIBLES AND THE RATE OF INFANT MORTALITY

The formula should allow proportionately more funds to go to states where infant mortality is particularly severe either generally or in one segment of the population, for example, where nonwhite infant mortality rates are makedly higher than white rates.

Eligibility

CLEARLY LABEL THE PROGRAM PREVENTIVE AS WELL AS REMEDIAL

Although this provision is now in the regulations, it should also be explicit in the law. The logic of WIC is to prevent the consequences of malnutrition before they begin.

ADOPT THE SAME INCOME ELIGIBILITY CRITERIA AS OTHER CHILD NUTRITION PROGRAMS

The present variation among states in determining whether participants qualify for medical aid, and therefore WIC, should be replaced by a minimum income eligibility standard, with higher standards at state option.

MAKE THE ELIGIBILITY CRITERIA SUFFICIENTLY FLEXIBLE TO ALLOW FOR THE SPECIAL NEEDS OF INDIANS AND MIGRANTS

The particular problems of Indians who live off reservations and of migrants who move to different areas at different times of year, frequently cause people who are otherwise eligible to be left out of WIC benefits. The program design should explicitly include these populations.

INCLUDE WOMEN UP TO ONE YEAR POST PARTUM OR AFTER LOSS OF A CHILD

According to the American Public Health Association, "post partum mothers should be covered up to one year after birth or abortion. Low-income mothers are known to show the greatest nutritional depletion after pregnancy. This is true whether they breast feed their infants, abort, or deliver and do not breast feed. Low-income women also show a higher incidence of maternal morbidity and mortality and produce more infants who die or have handicapping conditions". Participation in WIC for a year instead of six weeks would help these women regain adequate nutritional status.

INCLUDE CHILDREN UP TO THE AGE OF SIX

The great majority of children up to six are without supplemental food assistance. They are too young to be included in any program of child nutrition other than the Special Food Services Program, which reaches only 8.2 percent of low-income children. The Commodity Supplemental Food Program includes children up to age six, and WIC ought to do so as well.

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Administrative Costs

DOUBLE OR TRIPLE ADMINISTRATIVE COST ALLOWANCES

The present 10 percent allowance is not adequate to cover costs. This discourages clinics from applying for WIC and makes it impossible to have a program in many needy areas where there are no health facilities able to absorb the extra overhead.

ADD SPECIAL ADDITIONAL FUNDS FOR NUTRITION EDUCATION AND OUTREACH

Nutrition education is vital to the effectiveness of WIC; women must learn why certain foods are important, and become involved in better planning while they are pregnant. Also, a program's capacity for outreach and publicity will determine whether it can reach all eligible participants in its area.

BASE ADMINISTRATIVE REIMBURSEMENT ON THE NUMBER OF PARTICIPANTS INSTEAD OF A PERCENTAGE OF TOTAL FOOD COSTS

As long as the administrative allowance is based on food costs, there will be an incentive to maximize those costs in order to get enough overhead to run the program. The reimbursement should be based on caseloads in the form of a sliding scale which allows more money per person for smaller projects.

PROVIDE START-UP COSTS

Extra funds up to two months' program budget costs should be allowed in addition to the annual budget.

Evaluation

REDESIGN THE EVALUATION OF WIC TO STUDY PROGRAM EFFECTIVENESS RATHER THAN BASIC MEDICAL RESEARCH INFORMATION

The beneficial effects of improved fetal and infant nutrition in preventing death and disability among children is already scientifically established. The greater incidence of malnutrition among poor families is also well known. The WIC program should not be burdened with a primary research component to reconfirm accepted facts. If more detailed and long-range scientific information is desirable, it should not be sponsored by the Department of Agriculture in the guise of a food and nutrition program.

The focus of WIC evaluation should instead be on ways to make nutritious food supplements as effective as possible in achieving the goal of eradicating malnutrition among American children. Evaluation should concentrate on questions such as (a) what combination of foods is both nutritionally effecive and acceptable to local participants? (b) how can local spon-

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sors best combine nutrition education with food distribution? (c) how long a period of participation and follow-up is necessary to guarantee significant nutritional results? (d) how can the mutual support of food distribution programs and other health care services be enhanced? (e) what are the relative costs of different kinds of distribution schemes?

The responsibility for such evaluation should rest with state health departments, which can adapt a study to their own priorities and range of programs. Not every clinic should be required to participate in gathering evaluation data. Evaluation funds should be separately designated and sufficient to insure competent professional implementation.

Many health departments will, of course, wish local clinics to keep significant medical records on participants in the WIC program in connection with their general health care service. Heights, weights and measurements are frequently a standard part of prenatal and child care, and should be an important part of patient education. But few clinics have the trained personnel and precise record keeping capacity to participate in a basic scientific research program; to try to extract new and reliable medical knowledge from a broad scale food distribution program is both inefficient and inconclusive.

Local Grantee Qualifications

GIVE EQUAL PRIORITY TO PRIVATE NON-PROFIT GROUPS SERVING COMMUNITY WELFARE NEEDS

Applications should not be restricted to clinics. Any group that can find a subcontractor for the health component of WIC should be given full consideration. This would attract programs to areas that are not served by public health clinics and help communities participate more actively in the overall goals of the program.

MAKE CLEAR THAT IRS TAX-EXEMPTION IS NOT A REQUIREMENT FOR PARTICIPATION

Although the present legislation does not require tax-exemption, the new legislation should specifically prevent USDA from imposing this unnecessary burden. Any reasonable evidence of non-profit status should be acceptable.

ESTABLISH A FAIR HEARING PROCEDURE FOR REJECTED APPLICANTS

Just as participants declared ineligible have a right to a fair hearing process, so should applicant organizations which are turned down.

REQUIRE LOCAL PROGRAMS TO ESTABLISH PARTICIPANT ADVISORY COUNCILS

Requiring the involvement of those who are eligible, or whose children are eligible, for WIC would increase the program's responsiveness to the

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people it serves. It would also help participants become more knowledgeable and sophisticated about the conditions of their lives, rather tha.. passive recipients of aid.

ALLOW WIC TO OPERATE IN AREAS WHERE A COMMODITY SUPPLEMENTAL FOOD PROGRAM EXISTS

Although USDA has changed its policy to allow areas to apply for WIC where commodity programs have closed, it generally does not fund WIC applicants from supplemental program areas. Communities should not have to trade one for the other. Areas that want both, and are capable of administering them, ought to have both until all eligible people in the area are served.

State and National Administration

REQUIRE STATE AGENCIES TO REIMBURSE THE EXPENSES OF LOCAL PROGRAMS WITHIN A MAXIMUM OF FOUR WEEKS AFTER RECEIVING A VALID REQUEST

State delays in reimbursement have made it very difficult to keep local programs operating and have sometimes caused grocers to drop out of the program. States must ensure that local programs receive timely reimbursements.

REQUIRE STATES TO INFORM PROGRAM ADMINISTRATORS AND PARTICIPANT ADVISORY COMMITTEES IN WRITING AT LEAST TEN WORKING DAYS BEFORE POLICY CHANGES OR NEW POLICIES ARE TO BECOME EFFECTIVE

Adequate consultation beforehand would be ideal, but in any case administrators and participants must be given a chance to consider and react.

REQUIRE USDA TO INFORM STATES IN WRITING AT LEAST FIFTEEN WORKING DAYS BEFORE PROPOSED POLICY CHANGES OR NEW POLICIES ARE TO BECOME EFFECTIVE

State directors deserve the same opportunity to share their views with USDA before changes in policy, to be sure that all potential effects are considered.

The Food Package

ALLOW CHANGES IN THE FOOD PACKAGE TO ALLOW FOR CULTURAL DIFFERENCES

Local nutritionists should have the right to substitute nutritious foods which are more likely to be acceptable, subject to general guidelines.

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ALLOW SUBSTITUTIONS IN THE FOOD PACKAGE WHEN IT IS MEDICALLY NECESSARY

Occasional problems arise with allergies or other medical conditions. For example, it should be possible to substitute soybased formula for children who are allergic to milk. . . .

• • • •

In summary, The Children's Foundation sees the need for a number of changes in the WIC program, to make it more flexible in its food package, more comprehensive in its coverage of low-income women and children, more imaginative in its encouragement of sponsoring organizations and innovative delivery systems, more realistic in its administrative costs, and more useful in its evaluation. We hope as well that the Department of Agriculture will become a more convinced and effective administrator of WIC.

But our support for the program remains steadfast. We have seen countless children whose lives are being changed by this opportunity for adequate nutrition, we have talked to countless health professionals who have at last an effective means of combatting malnutrition.

We know that WIC already makes a difference; we are convinced that a revised and expanded program will at last begin to defeat the sorrowful and expensive consequences of malnutrition in America.

> The real horror of malnutrition is that it is not a rare disease. Malnutrition is a much bigger problem than is leukemia. If we could find ways to stop leukemia altogether in this age group, there would only be a small, or virtually no effect on the world's population. But if we found ways to stop malnutrition, it would have an almost immeasurable effect on the world.
>
> *Dr. Donald Pinkel*
> *Memphis Commercial Appeal*
> *December 27, 1970.*

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FOOTNOTES

1. The material in this chapter is based on documentation from sources listed in Appendix A.

2. Agricultural Research Service, Department of Agriculture, **National Household Food Consumption Survey,** 1965.

3. Data from National Center for Health Statistics, in Senate Select Committee on Nutrition and Human Needs staff report, January, 1974, p. 9.

4. Ibid. p. 47.

5. **Congressional Record,** August 16, 1972.

6. **Implementation and Status of the Special Supplemental Food Program for Women, Infants, and Children,** Department of Agriculture, Food and Nutrition Service, Report to the Congress (Washington: U.S. Government Printing Office, October, 1974) p. 4.

7. Public Law 93-150, approved November 7, 1973.

8. Public Law 93-326, approved June 30, 1974.

9. **Observations on Evaluation of the Special Supplemental Food Program,** Food and Nutrition Service, Department of Agriculture, Comptroller General of the United States, (Washington: U.S. Government Printing Office, 1974) p. ii.

10. Food and Nutrition Service, Department of Agriculture, op. cit. p. 9.

11. Public Law 92-433, [86 Stat. 724] Section 17(a).

12. The law states that the Secretary shall make cash grants to the health department or comparable agency of each state for the purpose of providing funds to "local health or welfare agencies or private nonprofit agencies of such state serving local health or welfare needs ..." (Public Law 92-433, Section 17(a)).

13. The regulations state that "a local agency is eligible to apply for participation in the WIC Program if:

> (a) It provides health services, free or at less than the full charge customarily made for such services, to residents of an area in which a substantial proportion of the persons have low incomes;
>
> (b) It serves a population of women, infants or children which is at nutritional risk;
>
> (c) Its staff includes competent professionals who interview or examine persons receiving health services;
>
> (d) It has the personnel, expertise, facilities and equipment necessary for performing the measurements, tests and collection of data and other material specified by FNS or its designee for the WIC Program; and
>
> (e) It maintains or is able to maintain adequate medical records."

14. Letter of August 8, 1974 to Leeman Barge, Assistant Program Director, USDA Regional Office, Atlanta.

15. Letter from Vermont State Program Director to Regional FNS Office, June 5, 1974.

16. **Maternal, Fetal, and Infant Nutrition,** Hearings before Senate Select Committee on Nutrition and Human Needs, June 5, 1973.

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17. These responses are taken from replies to a telegram survey from the office of Senator George McGovern, and from replies to a written questionnaire circulated by The Children's Foundation.

18. Dr. Rose Langham, Hearings before House Subcommittee on Elementary, Secondary and Vocational Education, March 4, 1975.

19. **To Save The Children**, staff report of Senate Select Committee on Nutrition and Human Needs, January, 1974, p. 124.

20. Calculated from Food and Nutrition Service, USDA figures, March, 1975.

21. See Appendix C.

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Government Reports on the Special Supplemental Food Program For Women, Infants, and Children

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APPENDIX C

Need For WIC — The Special Supplemental Food Program For Women-Infants-Children (P. L. 92-433, Section 17)

State	Number Eligible[1]			Number Reached[2]				Infant Mortality[3]		
By Region	Pregnant Women[a]	Infants, Children 1-3 years[b]	Total Eligible	WIC Authorized Caseload[a]	Commodity Supplemental Food[b]	Total (projected) Participants	Percent Reached	State Rank[a] (Non white)	Non-White[b]	White[c]
Northeast										
Conn.	3,819	36,066	39,885	14,291	47	14,338	35.9	16	30.2	15.6
Del.	1,047	9,911	10,958	818	0	818	7.5	15	30.7	15.6
D.C.	2,216	20,706	22,922	0	11,200	11,200	48.8	19	29.7	23.0
Maine	2,363	20,074	22,437	1,150	0	1,150	5.1	29	24.6	21.5
Maryland	6,958	61,570	68,528	15,680	0	15,680	22.8	21	28.9	16.0
Mass.	8,518	73,824	82,342	10,847	0	10,847	13.1	37	15.5	17.5
N.H.	1,167	8,686	9,853	532	0	532	5.4	41	4.8	17.8
N.J.	10,326	95,716	106,042	14,983	358	15,341	14.4	16	30.2	17.5
N.Y.	35,747	325,124	360,871	66,101	*1,647	67,748	18.7	19	29.7	17.1
Pa.	22,100	175,198	197,298	36,297	0	36,297	18.4	5	35.1	17.9
R.I.	1,800	16,642	18,442	1,247	0	1,247	6.7	23	28.1	19.2
Vt.	929	7,278	8,207	19,000	0	19,000	100%+	42	0.0	17.8
Va.	12,431	106,356	118,787	0	0	0	0	11	33.3	17.2
W. Va.	6,842	52,116	58,958	5,825	0	5,825	9.8	25	27.5	23.2
Regional Total	116,263	1,009,267	1,125,530	186,771	13,252	200,023	**16%	—	—	—

*This figure represents the participation of Oneida County (1196), Rockland County (327), and Tioga County (124). The programs in Oneida and Rockland County have closed since December, 1974.
**Vermont omitted from this calculation.

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APPENDIX C

Need For WIC — The Special Supplemental Food Program For Women-Infants-Children (P. L. 92-433, Section 17)

State	Number Eligible[1]			Number Reached[1]				Infant Mortality[1]		
By Region	Pregnant Women[a]	Infants, Children 1-3 years[b]	Total Eligible	WIC Authorized Caseload[a]	Commodity Supplemental Food[b]	Total (projected) Participants	Percent Reached	State Rank[a] (Non white)	Non-White[b]	White[c]
Southeast										
Ala.	15,430	133,746	149,176	9,996	0	9,996	6.7	4	35.8	18.4
Fl.	19,588	157,106	176,694	13,561	0	13,561	7.6	6	34.4	17.5
Ga.	16,637	150,918	167,555	18,882	0	18,882	11.2	8	33.8	17.2
Ky.	12,930	103,018	115,948	11,838	0	11,838	10.2	24	28.0	18.8
Miss.	13,799	133,006	146,805	6,621	0	6,621	4.5	1	39.7	19.3
N.C.	17,934	150,820	168,754	13,061	1,895	14,956	8.8	4	35.8	19.2
S.C.	10,709	100,590	111,299	28,145	***3,829	31,974	28.7	16	30.2	18.6
Tenn.	15,055	120,340	135,395	5,392	17,380	22,772	16.8	13	32.1	19.5
Regional Total	122,082	1,049,544	1,171,626	107,496	23,104	130,600	11.1	—	—	—

***This figure represents the participation of five programs. These five programs closed February 1, 1975.

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West Central										
Ark.	9,413	74,692	84,105	4,000	10,625	14,625	17.3	13	32.1	18.2
Colo.	4,738	40,442	45,180	6,309	9,868	16,177	35.8	32	23.2	19.8
La.	16,788	161,220	178,008	31,208	12,524	43,732	24.5	12	32.3	19.5
Mont.	1,650	13,386	15,036	8,389	0	8,389	55.7	30	24.5	21.3
N.M.	4,088	41,846	45,934	2,720	0	2,720	5.9	21	28.9	19.7
N.D.	1,676	13,452	15,128	1,420	436	1,856	12.2	38	15.2	14.2
Okla.	8,369	63,278	71,647	603	0	603	.8	35	18.1	16.4
S.D.	2,152	18,292	20,444	1,852	2,277	4,129	20.2	2	37.4	17.1
Tex.	36,839	352,390	389,229	62,603	0	62,603	16.0	13	32.1	19.5
Utah	2,130	22,532	24,662	0	6,014	6,014	24.3	40	10.4	15.3
Wy.	682	6,532	7,214	653	0	653	9.0	27	25.8	19.8
Regional Total	88,525	808,062	896,587	119,757	41,744	161,501	18.0	–	–	–
Mid-West										
Ill.	20,019	173,678	193,697	16,140	4,531	20,671	10.6	10	33.6	18.4
Ind.	8,881	72,416	81,297	2,057	0	2,057	2.5	7	34.2	18.3
Iowa	5,735	39,864	45,599	660	6,104	6,764	14.8	17	30.1	18.5
Kansas	4,959	37,690	42,649	3,092	0	3,092	7.2	19	29.7	16.7
Mich.	14,750	133,582	148,332	16,993	18,243	35,236	23.7	18	30.0	18.5
Minn.	7,158	48,972	56,130	7,044	666	7,710	13.7	36	17.3	17.6
Mo.	12,098	87,970	100,068	3,751	8,417	12,168	12.1	9	33.7	17.0
Neb.	4,959	23,798	28,757	460	2,598	3,058	10.6	3	36.3	18.4
Ohio	18,744	152,014	170,758	30,128	0	30,128	17.6	22	28.3	17.2
Wis.	7,570	55,688	63,258	2,009	0	2,009	3.1	28	25.7	16.3
Regional Total	104,873	825,672	930,545	82,334	40,559	122,893	13.2	–	–	–

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APPENDIX C

Need For WIC — The Special Supplemental Food Program For Women-Infants-Children (P. L. 92-433, Section 17)

State	Number Eligible [1]			Number Reached [2]					Infant Mortality [3]	
By Region	Pregnant Women [a]	Infants, Children 1-3 years [b]	Total Eligible	WIC Authorized Caseload [a]	Commodity Supplemental Food [b]	Total (projected) Participants	Percent Reached	State Rank [a] (Non white)	Non-White [b]	White [c]
Western										
Alaska	637	7,382	8,019	150	0	150	1.8	20	29.0	21.3
Ariz.	4,760	47,768	52,528	21,901	0	21,901	41.6	26	27.0	16.4
Calif.	38,749	289,744	328,493	63,383	11,433	74,816	22.7	31	23.9	16.2
Hawaii	1,234	13,148	14,382	1,180	0	1,180	8.2	34	18.9	18.0
Idaho	1,648	15,098	16,746	995	0	995	5.9	33	21.6	16.5
Nevada	783	6,950	7,733	2,533	0	2,533	32.7	19	29.7	22.6
Oregon	4,227	32,206	36,433	8,194	0	8,194	22.4	39	14.8	15.7
Wash.	6,041	51,921	57,962	16,863	0	16,863	29.0	27	25.8	18.2
Regional Total	58,079	464,217	522,296	115,199	11,433	126,632	26.1	—	—	—
National Total	489,822	4,156,762	4,646,584	611,557	130,092	741,649	15.9	—	—	—

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Puerto Rico	23,365	0	23,365
Virgin Islands	493	0	493
TOTAL: ALL GRANTEES	635,415	130,092	765,507

Source:

1. a) Table 182. *Poverty Status in 1969 of Families and Persons for Regions, Divisions and States: 1970.*

(Total poor persons multiplied by 1.8% to determine number of pregnant women in poverty at any given time. Figure of 1.8% obtained from the Bureau of the Census.)

1 b) Harrison Tabulations,
Bureau of the Census,
Division of Poverty Statistics
(unpuslished)

Source: Department of Commerce
SESA
Bureau of the Census
Washington, D.C. 20233

"Families and Children by Family Income and Age of Child" (by State) 1970 Census data.

2 a) Official USDA participation ceilings. These figures indicate the maximum monthly participation permitted, not actual participation.

2 b) USDA Report: Food and Nutrition Service, Program Reporting Staff. Actual participation figures: December, 1974 (most recent available).

3) "Statistical Survey: Infant Birth and Death Data." Table 1 "Infant Deaths and Infant Mortality Rates per 1,000 Live Births by State and Color, 1970 Provisional Data." Data from the National Center for Health Statistics.

3 a) State with highest non-white infant mortality rate ranked #1.
State with lowest non-white infant mortality rate ranked #42.

3 b) Table 1. Infant Deaths.

3 c) Table 1. Infant Deaths.

Prepared by: The Children's Foundation
June, 1974
Revised, March, 1975

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APPENDIX D[1]

1975 WIC CASELOADS AND BUDGETS

State by Region	January Authorized Caseload	Allocated Budget
	NORTHEAST	
Connecticut	14,291	$ 3,721,200
Delaware	818	255,500
Maine	1,150	291,200
Maryland	15,680	2,099,200
Massachusetts	10,847	2,045,500
New Hampshire	532	92,400
New Jersey	14,983	3,699,800
New York	66,101	12,849,900
Pennsylvania	36,297	3,046,200
Rhode Island	1,247	202,300
Vermont	19,000	4,135,700
West Virginia	5,825	1,265,100
Regional Total	186,771	$34,341,600
	SOUTHEAST	
Alabama	9,996	$ 2,203,400
Florida	13,561	3,003,200
Georgia	18,882	2,824,600
Kentucky	11,838	3,161,200
Mississippi	6,621	1,159,300
North Carolina	13,061	2,689,900
South Carolina	28,145	4,041,500
Tennessee	5,392	1,105,100
Regional Total	107,496	$20,188,200

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MIDWEST		
Illinois	16,140	$ 4,209,900
Indiana	2,057	579,100
Iowa	660	213,400
Kansas	3,092	651,100
Michigan	16,993	2,405,900
Minnesota	7,044	1,358,800
Missouri	3,751	481,000
Nebraska	460	47,400
Ohio	30,128	6,035,200
Wisconsin	2,009	579,300
Regional Total	82,334	$16,561,100
WEST CENTRAL		
Arkansas	4,000	$ 1,117,300
Colorado	6,309	1,344,600
Louisiana	31,208	3,302,900
Montana	8,389	1,075,300
New Mexico	2,720	929,400
North Dakota	1,420	153,000
Oklahoma	603	103,100
South Dakota	1,852	430,800
Texas	62,603	13,730,700
Wyoming	653	68,700
Regional Total	119,757	$22,255,800
WESTERN		
Alaska	150	$ 59,600
Arizona	21,901	4,582,200
California	63,383	11,703,000
Hawaii	1,180	475,000
Idaho	995	142,700

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APPENDIX D (Continued)

WESTERN (continued)		
Nevada	2,533	$ 617,300
Oregon	8,194	2,136,300
Washington	16,863	6,024,100
Regional Total	115,199	$25,740,200

TERRITORIES		
Puerto Rico	23,365	$ 3,022,100
Virgin Islands	493	101,900
Territory Total	23,858	$ 3,124,000
National Total	635,415	$122,210,900[2]

1. Data Based on USDA-FNS January 13, 1975 *Summary of Caseloads and Grants* Printout.
2. This figure represents 12, 9, 7 and 6 month grants. The annualized budget for all grants totals just under $200 million.

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APPENDIX E

LIST OF LOCAL SPONSORS

Alabama:
Jefferson County Department of Health; Tri-County District Health Service: Morgan, Limestone and Lawrence Counties; Coffee County Health Department; Geneva County Health Department; Lowndes County Health Services Assn., Inc.; Mobile County Board of Health.

Alaska:
Community Health Section, Alaska Division of Public Health: Barrow and Wainwright.

Arizona:
Cochise County Health Department; Coconino County Health Department; Pinal County Health Department; Navajo WIC Program, Fort Defiance; Gila County Health Department; Navajo County Health Department; Mohave County Health Department; Santa Cruz County Health Department; Maricopa County Health Department; Yavapai County Health Department; Sacaton PHS Indian Hospital; Graham County Health Department; The Papago Nutrition WIC Program, Sells; Apache County Health Department; Pima County Health Department; Fort Yuma Indian Hospital and Service Unit; Yuma County Health Department.

Arkansas:
Arkansas Southeastern WIC Project: Arkansas, Ashley, Bradley, Calhoun, Chicot, Cleveland, Desha, Drew, Lincoln, Monroe, Phillips, Prairie and Woodruff Counties.

California:
Alviso Family Health Center; Kern County Economic Opportunity Corporation; Riverside-San Bernardino County Indian Health, Inc.; Clinica De Salubridad De Campesinos, Brawley; Charles R. Drew Health Center, Inc., East Palo Alto; Fresno County Economic Opportunities Commission; Indian Free Clinic, Inc., Huntington Park; Lake County Health Department; East Los Angeles Maternity and Infant Care Project; Martin Luther King, Jr. Hospital, Los Angeles; Westland Health Center, Los Angeles; Central Los Angeles Health Project; Elias Chico Family Health Center, Los Angeles; St. Mary Medical Center, Long Beach; Contra Costa County Head Start, Martinez; Merced Family Health Center; Stanislaus Rural Health Care Program, Modesto; Alameda County Health Care Services Agency; Oakland Children's Hospital Medical Center; West Oakland Health Council; Orange Cove Family Health Center, Inc.; Pasadena Department of Public Health; Monterey County Health Department; San Diego and Oceanside American Red Cross Nursing and Health Programs; County of San Diego Department of Public Health; Urban Indian Health Board, Inc., San Francisco; Santa Clara Valley Medical Center; North County Health Project, San Marcos; Orange County Health Department; Santa Barbara County Health Department;

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Sonoma County Public Health Service; San Joaquin Local Health District, Stockton; United Indian Health Services, Inc., Trinidad; Solano County Department of Public Health; Ventura County Health Service Agency.

Colorado:
Tri-County District Health Department: Adams, Denver and Arapahoe Counties; Otero County Health Department; Jefferson County Health Department; Las Animas-Huerfano Counties District Health Department.

Connecticut:
Bridgeport WIC Program; Fairhaven Community Health Clinic, New Haven; Hill Health Center, New Haven; Yale-New Haven Hospital; Day Kimball Hospital Pediatric Center, Putnam; Stamford Health Department; Waterbury Health Department.

Delaware:
Department of Health & Social Services, Office of Nutrition Services, Division of Public Health.

Florida:
Broward County Health Department; Okaloosa County Health Unit; Duval County Public Health Division; Dade County Department of Public Health; Children and Youth Comprehensive Health Care Program, University of Miami School of Medicine; Collier County Health Department; Brevard County Health Department.

Georgia:
Bacon County Health Department; N.E. Georgia Health District: Clarke, Madison, Elbert, Greene, Jackson, Ogelthorpe, Morgan, Walton, Oconee, and Barrow Counties; M & I Care Project, Grady Memorial Hospital, Atlanta; Southside Comprehensive Health Clinic, Atlanta; M & I Care Project, Augusta; Glynn County Health Department; Columbus Health Department; Metropolitan East Health Department, Decatur; North Health District: Hall, Union, Habersham, Rabun, White, Forsyth, Lumpkin, Dawson, Towns, Banks and Stephens Counties; Atkinson County Department of Human Resources; Service Area 15, Reidsville, Chatham County Health Department, Southeast Health District, Waycross.

Hawaii:
Kaiser Foundation Health Plan Project, Honolulu.

Idaho:
Southwest District Health Department: Adams, Canyon, Gem, Owyhee, Payette and Washington Counties; Fort Hall Indian Health Center; Northern Idaho PHS Indian Health Center, Lapwai.

Illinois:
Tri-County Health Department: Alexander, Pulaski and Union Counties; Fulton County Health Department; Chicago Board of Health; Mile Square Health Center, Chicago; East Side Health District, East St. Louis; Quadri-County Health Department: Pope, Hardin, Massac and Johnson Counties; Logan County Health Department; Peoria Health Department; Winnebago Department of Public Health, Rockford; Rock Island Health Council.

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Indiana:
Gary City Health Department; Health and Hospital Corporation of Marion County, Division of Public Health, Indianapolis.

Iowa:
Maternal Health Center, Inc., Davenport.

Kansas:
Western Kansas Migrant Health Service, Garden City; Hutchison-Reno County Health Department; Topeka-Shawnee County Health Department; Wichita-Sedgwick County Health Department.

Kentucky:
FIVCO District Health Department: Boyd, Carter, Elliot and Lawrence Counties; Bowling Green-Warren County Health Department; Northern Kentucky District Health Department: Kenton and Campbell Counties; Muhlenberg County Health Department; Hazard Appalachian Regional Hospital; Breathitt County Well Baby Care Clinic; Children and Youth Project, University of Louisville; Louisville and Jefferson County Department of Health; Park-DuValle Neighborhood Health Center, Inc., Louisville; Rowan County Health Department; Paducah-McCracken County Health Department; Bourbon County Health Department; Maternity and Infant Care Project, Pineville; Lake Cumberland District Health Department: Clinton, Cumberland, McCreary, Pulaski and Wayne Counties.

Louisiana:
Louisiana State WIC Program, New Orleans: Vermilion, Rapides, Bienville, Bossier, St. Bernard, Red River, Acadia, Beauregard, Washington, St. Mary, St. Helena, Jefferson, Claiborne, Terrebonne, Jefferson Davis, Lafayette, East Carroll, Vernon, DeSoto, Sabine, Ouachita, Assumption, Allen, Natchitoches, St. Landry, Caddo-Shreveport, West Feliciana, Lafourche, Evangeline and Tangipahoa Parish Health Units.

Maine:
Bangor Health Department; York County Community Action Corporation.

Maryland:
Comprehensive Child Health Care Program, Johns Hopkins University, Baltimore; Johns Hopkins Hospital, Baltimore; Baltimore City Health Department; Prince Georges County Health Department; Montgomery County Health Department; Garrett County Memorial Hospital; South County Family Health Center, West River; Carroll County Health Department; Provident Comprehensive Neighborhood Health Center, Baltimore.

Massachusetts:
The Cambridge Hospital; Upham's Corner Health Center, Dorchester; Columbia Point Health Center, Dorchester; Fall River Model Cities; Roxbury Comprehensive Community Health Center.

Michigan:
Calhoun County Health Department; Detroit Health Department; Delta-Menominee jdistrict Health Department, Escanaba; Kent County Health Department; Family Health Center, Inc., Kalamazoo; Ingham County Health Department; Central Michigan District Health Department: Arenac, Clare,

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Gladwin, Isabella, Osceola and Roscommon Counties; Muskegon County Maternity Care Project; Luce-Mackinac-Alger-Schoolcraft District Health Department; Saginaw County Health Department.

Minnesota:
Aitkin County Public Health Nursing Service; Minneapolis Health Department; Mille Lacs Indian Reservation, Onamia; Olmsted County Health Department; St. Paul Division of Public Health; Minnesota Department of Health - N.W. District, Bemidji; White Earth Indian Reservation.

Mississippi:
Hinds-Rankin Maternal & Infant Care Project; County Health Improvement Project, Lexington; Sharkey-Issaquena County Health Department; Warren County Health Department.

Missouri:
Columbia City Health Department; Southeast Missouri Health Department, Hayti; The Children's Mercy Hospital, Kansas City; Kansas City General Hospital & Medical Center; Children and Youth Project, Kirksville College of Osteopathic Medicine; Phelps County Health Department.

Montana:
Montana State Department of Health: Indian Health Service, Billings; Maternal & Child Health Program, Billings; Rocky Boy Service Unit, Box Elder; Family Planning Services, Browning; Butte Family Service Center; PHS Indian Hospital, Crow Agency; Cascade City-County Health Department; Fort Belknap Service Unit, PHS Indian Hospital, Harlem; Hill County Health Department; Lewis & Clark Children & Youth Project, Helena; Flathead County Health Department; Northern Cheyenne Service Unit, PHS Indian Health Center, Lame Deer; Lincoln County Health Department; Custer County Health Department; Missoula City-County Health Department; Fort Peck Service Unit, PHS Indian Health Unit; PHS Indian Health Center, St. Ignatius; Sanders County Health Department.

Nebraska:
Winnebago U.S. Public Health Service Indian Hospital.

Nevada:
White Pine County WIC Project; Mineral County WIC Project; Economic Opportunity Board of Clark County; Operation Life, Inc., Las Vegas; Economic Opportunity Board of Washoe County; Lyon County WIC Project.

New Hampshire:
Strafford County Prenatal Program; Conway Children and Youth Project, North Conway; Suncook Children and Youth Project.

New Jersey:
Camden City Health Center; Prenatal Satellite Clinic, St. Mary's Hospital, Hoboken; Newark Department of Health & Welfare; Sussex County Health Department; Passaic Human Resources Administration; Comprehensive Neighborhood Health Services Center, Plainfield; M.C.O.S.S. Family Health & Nursing, Red Bank; Trenton Neighborhood Health Center.

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New Mexico:
Albuquerque Primary Health Care System; Maternity & Infant Care Project, Albuquerque; Presbyterian Medical Service, Cuba-Checkerboard Health Center, Cuba.

New York:
Whitney M. Young, Jr. Community Health Center, Albany; Allegany County Public Health Nursing Service; Albert Einstein College of Medicine of Yesheva University, Bronx; Bronx-Lebanon Hospital; Montefiore-Morrisania Comprehensive Health Care Center, Bronx; Brownsville Ambulatory Pediatric Care Unit, Brooklyn; C & Y Project #628, C.A.T.C.H. Program, Brooklyn; Child Health Maintenance Program #653, Brookdale Hospital Medical Center, Brooklyn; LBJ Health Complex, Brooklyn; Sunset Park Family Health Center, Brooklyn; Erie County Health Department; Suffolk County Department of Health; Livingston County Department of Health; Mt. Vernon Neighborhood Health Center; Maternal & Infant Care-Family Planning, New York; Human Resources Administration, New York; New York City Department of Health, Child Health Station; Neighborhood Health Services Program, New York; Nena Health Council, New York; New Gouveneur Hospital, New York; Health and Hospital Corporation at Bellevue Hospital, New York; New Rochelle Hospital Medical Center; Chenango Memorial Hospital, Norwich; Rockland County Health Department; Project PRYME, C & Y Project #610, Rockaway Health Center, Queens; The Anthony L. Jordan Health Center, Rochester; Carver Comprehensive Community Health Center, Schenectady; Onondaga County Department of Health; Oneida County Department of Health; North Country Children's Clinic, Inc., Watertown.

North Carolina:
Orange-Chatham Comprehensive Health Services, Inc., Chapel Hill; Mecklenburg County Health Department; Lincoln Community Health Center, Durham; Pasquotank-Perquimans-Camden-Chowan District Health Department; Gaston County Health Department; Children & Youth Project, Guilford County Health Department; Johnston County Health Center; Waltonsburg Community Health Clinic; Warren County Health Department; Family Health Center, Forsyth County/Winston-Salem.

North Dakota:
Division of Maternal & Child Health, Bismarck.

Ohio:
Akron Health Department; Wood County Health Department; Eastern COAD Region, Monroe-Noble Child Development, Caldwell; Cincinnati Health Department; City of Cleveland M & I, Cuyahoga County Hospital; Hough-Norwood Family Health Care Center, Cleveland; Ironton-Lawrence County Community Action Organization; Ohio State University Hospital Nutrition Clinic, Out-patient Department, Columbus; Montgomery County General Health District; Tuscarawas County Health Department; Migrant Rest Center: Henry and Fulton Counties; Lincoln Heights Health Center, Inc.; Toledo-Lucas County Health Department; Greene County Health Department.

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Oklahoma:
Cleveland County Health Department: Cleveland and McLain Counties; Tulsa Neighborhood Comprehensive Health Services, Inc.

Oregon:
Clatsop County Health Department; Coos County Health Department; Washington County Department of Public Health; Jefferson County Health Department; Lincoln County Health Department; Nyssa Service Center; Clackamas County Health Department; Maternal & Infant Care Project, Portland; Crook County Health Office; Centro de Salubridad, Salem; Marion County Health Department; Wasco-Sherman County Health Department; Tillamook County Health Office; Malheur County Health Office; Warm Springs Indian Reservation.

Pennsylvania:
Broad Top Area Medical Center, Inc.: Bedford and Huntingdon Counties, part of Fulton County; Temple University Department of Obstetrics/Gynecology, Philadelphia; Division of Maternal & Child Health, Philadelphia; Children & Youth Program, Thomas Jefferson University Hospital, Philadelphia; Allegheny County Health Department; Crozer-Chester Medical Center, Upland, Chester; Economic Opportunity Council of Reading & Berks County, Inc.; Community Progress Council, York; Maternal Health Services of Northeastern Pennsylvania: Luzerne, Lackawanna, Wyoming, Wayne, and Pike Counties.

Puerto Rico:
Commonwealth of Puerto Rico Department of Health, San Juan.

Rhode Island:
Women & Infant's Hospital of Rhode Island, Prenatal & Pediatrics Clinics, Providence.

South Carolina:
Allendale County Health Department; Beaufort County Health Department; Jasper County Health Center; Charleston County Health Department; Franklin C. Fetter Family Health Center, Charleston; Richland County Health Department; Florence County Health Department; Appalachia II District Department: Greenville and Pickens Counties; Lancaster County Health Department; Berkeley County Health Department; Wateree Health District: Sumter, Clarendon, Lee and Kershaw Counties.

South Dakota:
Rosebud U.S. Public Health Service, Indian Health Service Hospital; Sisseton Service Unit Indian Health Service; Yankton Sioux Tribe/Wagner Indian Health Service.

Tennessee:
Upper Cumberland Human Resource Agency: Cannon, Clay, Cumberland, DeKalb, Fentress, Jackson, Macon, Overton, Pickett, Putnam, Smith, Van Buren, Warren and White Counties; Stewart County Health Department; Upper East Tennessee Human Development Agency, Kingsport.

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Texas:
Austin-Travis County Health Department; Montgomery County Health Department; Community Council of Bee County; C & Y Project #660, Driscoll Foundation Children's Hospital, Corpus Christi; Coastal Bend Migrant Council, Inc.: Nueces and San Patricio Counties; Centro de Salud Health Center, Crystal City; Children & Youth Project, University of Texas Health Science Center, Pediatrics Department, Dallas; City of Dallas Public Health Department; Maverick County Child Health; Public Health Region of the Adjoining Counties of Cameron and Hidalgo; The University of Texas Medical Center at Houston; Walker County Health Department; Galveston County Coordinating Community Clinics; Laredo-Webb County Health Department; Lubbock Well Baby Clinic; Community Action Council of South Texas, Rio Grande City; Migrant Health Project, Southwest Migrant Association, San Antonio; Denison-Sherman Grayson County Health Department; Community Action Resources Services, Inc., Bowie County; Waco-McLennan County Health Department; Maternity & Well Child Conference Clinic Programs, Wichita Falls, South Plains Health Provider Organization, Inc., Plainview; Su Clinica Familiar, Catholic Charities, Inc., Harlingen.

Vermont:
Statewide Project Department of Health: Barre, Bennington, Bradford, Brattleboro, Chester, Middlebury, Morrisville, Newport, Randolph, Rutland, St. Albans and St. Johnsbury.

Virgin Islands:
Bureau of Nutrition Services Virgin Islands Department of Health: St. Thomas and St. Croix.

Washington:
Washington State Rural Project: Asotin, Chelan, Clallan, Clark, Colville Indian Reservation, Cowlitz, Douglas, Ferry, Gray's Harbor, Kittitas, Klikitat, Mason, Pacific, Pend Orielle, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum and Whatcon Counties; Seattle-King County Health Department; Mary Bridge Children's Health Center, Tacoma; Farmworkers Family Health Center: Grant, Adams, Benton, Franklin, Walla Walla and Yakima Counties.

West Virginia:
Southern West Virginia Regional Health Council, Inc.: Mercer, Raleigh, Fayette, Summers and McDowell Counties; Early Childhood Development Project, Summerville.

Wisconsin:
Green Bay Area Free Clinic; Menominee County WIC Program; Great Lakes Inter-Tribal Council, Inc. Lac du Flambeau.

Wyoming:
Wind-River WIC Program, Ft. Washakie.

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NOTE: On April 1, 1975, after the report had gone to press, USDA announced the following 45 grantees:

Alaska:
Juneau Borough Health Center.

California:
*Marin County Health Department.

Connecticut:
Hartford Health Department.

Florida:
North Central Florida Maternity and Infant Care Project: Alachua, Baker, Bradford, Clay, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Marion, Suwanee, and Union Counties.

Georgia:
Effingham County Health Department.

Idaho:
Central District Health Department, Boise.

Illinois:
Illinois Migrant Council, Chicago.

Kentucky:
Lyon County Health Department.

Maryland:
*Calvert County Health Department.

Michigan:
Berrien County Health Department.

Minnesota:
Leech Lake Reservation Business Committee.

Mississippi:
Delta Comprehensive Health Center, Bolivar County; Medgar Evers Comprehensive Health Center, Clairbourne and Jefferson Counties; Voice of Calvary Health Center, Simpson County.

New Jersey:
*Cumberland County Health Department; Jersey City Department of Human Resources.

New Mexico:
*Six Sandoval Indian Pueblos, Inc.

New York:
Charles Drew Neighborhood Health Center, Bronx; *Harlem Hospital Center; *Kings County Hospital Center; New York City Health and Hospital Corp., Queens Hospital Center.

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North Carolina:
Martin-Tyrell-Washington Counties Health District; Region D WIC Program: Ashe, Avery, Allegeny, Watauga, Mitchell, Yancy, and Wilkes Counties.

North Dakota:
*Ft. Totten Health Center, Devil's Lake Sioux Reservation.

Ohio:
Barberton Health Department; *Portage County Health Department.

Oklahoma:
Mary Mahoney Memorial Health Center, Oklahoma City.

Oregon:
*Confederated Tribes of Umatilla Indian Reservation, Pendleton; Josephine County Health Department; Lane County Community Health and Social Services Department.

Pennsylvania:
*Hamilton Health Center, Harrisburg; *Monsour Medical Foundation, Westmoreland County.

South Dakota:
Brown County Health Department; Moody County Health Department and IHS Flandreau Field Unit.

Tennessee:
East Tennessee Region: Scott, Campbell, Claiborne, Union, Anderson, Morgon, Roane, Loudon, Jefferson, Blunt, Sevier Hamblen, Cocke, Granger and Monroe Counties; South Central Region WIC: Giles, Perry, Marshall, Hickman, Lincoln, Wayne, Bedford, Lewis, Moore, Lawrence, Coffee, Maury and Franklin Counties.

Texas:
*Centro de Salud Familiar La Fe, Inc., El Paso; *Ft. Bend Office of Early Childhood Development, Rosenberg; Ft. Worth Health Department; Houston Maternity and Infant Care Project; South Plains Community Action Association, Levelland.

Virginia:
*Alexandria Health Department.

*Grant funded pending completion of application.

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APPENDIX F

Public Law 92-433
92nd Congress, H.R. 14896
September 26, 1972

SPECIAL SUPPLEMENTAL FOOD PROGRAM

"SEC. 17. (a) During each of the fiscal years ending June 30, 1973, and June 30, 1974, the Secretary shall make cash grants to the health department or comparable agency of each State for the purpose of providing funds to local health or welfare agencies or private nonprofit agencies of such State serving local health or welfare needs to enable such agencies to carry out a program under which supplemental foods will be made available to pregnant or lactating women and to infants determined by competent professionals to be nutritional risks because of inadequate nutrition and inadequate income. Such program shall be operated for a two-year period and may be carried out in any area of the United States without regard to whether a food stamp program or a direct food distribution program is in effect in such area.

(b) In order to carry out the program provided for under subsection (a) of this section during the fiscal year ending June 30, 1973, the Secretary shall use $20,000,000 out of funds appropriated by section 32 of the Act of August 24, 1935 (7 U.S.C. 612(c)). In order to carry out such program during the fiscal year ending June 30, 1974, there is authorized to be appropriated the sum of $20,000,000, but in the event that such sum has not been appropriated for such purpose by August 1, 1973, the Secretary shall use $20,000,000, or, if any amount has been appropriated for such program, the difference, if any, between the amount directly appropriated for such purpose and $20,000,000, out of funds appropriated by section 32 of the Act of August 24, 1935 (7 U.S.C. 612(c)). Any funds exiended from such section 32 to carry out the provisions of subsection (a) of this section shall be reimbursed out of any supplemental appropriation hereafter enacted for the purpose of carrying out the provisions of such subsection, and such reimbursements shall be deposited into the fund established pursuant to such section 32, to be available for the purpose of such section.

(c) Whenever any program is carried out by the Secretary under authority of this section through any State or local or nonprofit agency, he is authorized to pay administrative costs not to exceed 10 per centum of the Federal funds provided under the authority of this section.

(d) The eligibility of persons to participate in the program provided for under subsection (a) of this section shall be determined by competent professional authority. Participants shall be residents of areas served by clinics or other health facilities determined to have significant numbers of infants and pregnant and lactating women at nutritional risk.

(e) State or local agencies or groups carrying out any program under this section shall maintain adequate medical records on the participants assisted to enable the Secretary to determine and evaluate the benefits of the nutritional assistance provided under this section. The Secretary and Comptroller General of the United States shall submit preliminary evaluation reports to the Congress not later than October 1, 1973; and not later than March 30, 1974, submit reports containing an evaluation of the program provided under this section and making recommendations with regard to its continuation.

(f) As used in this section—

(1) 'Pregnant and lactating women' when used in connection with the term at 'nutritional risk' includes mothers from low-income populations who demonstr-

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ate one or more of the following characteristics: known inadequate nutritional patterns, unacceptably high incidence of anemia, high prematurity rates, or inadequate patterns of growth (underweight, obesity, or stunting). Such term (when used in connection with the term 'at nutritional risk') also includes low-income individuals who have a history of high-risk pregnancy as evidenced by abortion, premature birth, or severe anemia.

(2) 'Infants' when used in connection with the term 'at nutritional risk' means children under four years of age who are in low-income populations which have shown a deficient pattern of growth, by minimally acceptable standards, as reflected by an excess number of children in the lower percentiles of height and weight. Such term, when used in connection with 'at nutritional risk,' may also include (at the discretion of the Secretary) children under four years of age who (A) are in the parameter of nutritional anemia, or (B) are from low-income populations where nutritional studies have shown inadequate infant diets.

(3) 'Supplemental foods' shall mean those foods containing nutrients known to be lacking in the diets of populations at nutritional risks and, in particular, those foods and food products containing high-quality protein, iron, calcium, vitamin A, and vitamin C. Such term may also include (at the discretion of the Secretary) any food product commercially formulated preparation specifically designed for infants.

(4) 'Competent professional authority' includes physicians, nutritionists, registered nurses, dieticians, or State or local medically trained health officials, or persons designated by physicians or State or local medically trained health officials as being competent professionally to evaluate nutritional risk."

Public Law 93-150
93rd Congress, H.R. 9639
November 7, 1973

SPECIAL SUPPLEMENTAL FOOD PROGRAM EXTENSION

SEC. 6 (a) The first sentence of section 17(a) of the Child Nutrition Act of 1966 is amended by striking out "and June 30, 1974," and inserting in lieu thereof the following: "June 30, 1974, and June 30, 1975,"; and by inserting after the word "State" each place it occurs the following: "Indian tribe, band, or group recognized by the Department of the Interior; or the Indian Health Service of the Department of Health, Education, and Welfare". The second sentence of such section 17(a) is amended by striking out "two-year" and inserting in lieu thereof "three-year".

(b) Section 17(b) of such Act is amended by inserting immediately after the second sentence thereof the following: "In order to carry out such program during the fiscal year ending June 30, 1975, there is authorized to be appropriated the sum of $40,000,000, but in the event that such sum has not been appropriated for such purpose by August 1, 1974, the Secretary shall use $40,000,000, or, if any amount has been appropriated for such program, the difference, if any, between the amount directly appropriated for such purpose and $40,000,000, out of funds appropriated by section 32 of the Act of August 24, 1935 (7 U.S.C. 612(c))."

(c) The second sentence of section 17(e) of such Act is amended by striking out "October 1, 1973" and "March 30, 1974" and inserting in lieu thereof "October 1, 1974" and "March 30, 1975", respectively.

SPECIAL SUPPLEMENTAL FOOD PROGRAM

SEC. 6. The third sentence of section 17(b) of the Child Nutrition Act of 1966 is amended by striking out "$40,000,000" each place it appears and inserting in lieu thereof "$100,000,000".

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The Children's Foundation was established in 1969 as a public, non-profit, national organization. We concentrate our efforts on achieving fully responsive food assistance programs at the national, state and local levels.

The Foundation is based in Washington, D.C. with regional offices in Atlanta, Georgia and a new one to be opened in the Southwest. During the past year area projects were located in Austin, Texas, Washington, D.C. and San Francisco, California. Our monitoring includes review and analysis of existing government and private programs, technical assistance to community groups working to improve or implement programs, newsletters and fact sheets sent to a wide variety of individuals and organizations, and advocacy of both long and short range solutions to problems of hunger and malnutrition in America.

Our work is supported by grants from The Field Foundation, The New World Foundation, The New York Foundation, The Rockefeller Brothers Fund, The Shalan Foundation, The D.J.B. Foundation, The American Legion Child Welfare Foundation and the Herman Goldman Foundation. Support for regional projects has come from The Southern Education Foundation, The Mary Reynolds Babcock Foundation, the Moody Foundation, The Rockefeller Foundation and The Eugene and Agnes Meyer Foundation.

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